

# Bretton Woods Adaptive, Inc. Summer Adaptive Program

## PARTICIPANT INFORMATION SHEET

\*PLEASE PRINT CLEARLY\*

DATE COMPLETED \_\_\_\_\_ UPDATED \_\_\_\_\_

### BACKGROUND INFORMATION

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Home Phone No: \_\_\_\_\_ Work No. \_\_\_\_\_

Cell/Mobile No. \_\_\_\_\_ Fax No. \_\_\_\_\_

E-Mail: \_\_\_\_\_ Website: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### EMERGENCY CONTACTS

Name	Relationship	Phone No.	Address / E-Mail

### HEALTH INSURANCE INFORMATION

Do you have health insurance? Y / N

If yes, company name \_\_\_\_\_ Policy/ID number \_\_\_\_\_

Primary physician name \_\_\_\_\_ Phone \_\_\_\_\_

## STUDENT INFORMATION

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Age: \_\_\_\_\_

Sex/Gender: **M / F** Weight: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Will you be accompanied by a Personal Care Assistant? **Y / N**

Are you nervous in the outdoors? **Y / N** Are you nervous in or around water? **Y / N**

Will you be able to refrain from behaviors that pose a risk to yourself and/or others? **Y / N**

May we use your picture? **Y / N**

## DISABILITY INFORMATION

Disability Diagnosis: \_\_\_\_\_

Date of Disability: At birth/other \_\_\_\_\_

Mobility Method: \_\_\_\_\_ Mobility Equipment: \_\_\_\_\_

Activity Length: \_\_\_ 1 hour \_\_\_ 2 hours \_\_\_ all day

Seizure Y/N Type: \_\_\_ Focal \_\_\_ Grand Mal \_\_\_ Petite Mal \_\_\_ N/A

Date of last seizure: \_\_\_\_\_

Shunt: **Y / N** Harrington Rods: **Y / N**

Prescribed Exercise Program: **Y / N**

Breathing Problems: **Y / N**

Receive Occupational Therapy: **Y / N**

Balance Problems: **Y / N**

Receive Physical Therapy: **Y / N**

Bladder/Bowel: \_\_\_ Bag

\_\_\_ Diaper

\_\_\_ Frequency

\_\_\_ Internal Catheter

\_\_\_ Other

Date of Last Surgery: \_\_\_\_\_

Type of Surgery: \_\_\_\_\_

Any Implants? \_\_\_\_\_

## DETAILS

	NO	✓ Check or List all that pertain (If YES)
<b>Medications</b> <u>Comments:</u>		<hr/> <hr/> <hr/> <hr/> <b>Side Effects:</b> _____ <b>Schedule:</b> _____
<b>Allergies</b> <u>Comments:</u>		<hr/> <hr/> <hr/>
<b>Hearing Impairment</b> <u>Comments:</u>		<input type="checkbox"/> Hearing Aid(s) <input type="checkbox"/> Left side impaired <input type="checkbox"/> Right side impaired <input type="checkbox"/> Total loss <input type="checkbox"/> Implants
<b>Motion (range) Impairment</b> <u>Comments:</u>		<input type="checkbox"/> Left arm <input type="checkbox"/> Right arm <input type="checkbox"/> Left leg <input type="checkbox"/> Right leg
<b>Sensation Impairment</b> <u>Comments:</u>		<input type="checkbox"/> Limited left side <input type="checkbox"/> Limited right side <i>No sensation:</i> <input type="checkbox"/> Below ankles <input type="checkbox"/> Below knees <input type="checkbox"/> Below waist <input type="checkbox"/> Below chest <input type="checkbox"/> On left side <input type="checkbox"/> On right side
<b>Sports/Interests</b> <u>Comments:</u>		<input type="checkbox"/> Cross country skiing <input type="checkbox"/> Cycling <input type="checkbox"/> Fitness <input type="checkbox"/> Fundraising <input type="checkbox"/> Golf <input type="checkbox"/> Hiking <input type="checkbox"/> Rafting <input type="checkbox"/> Riding <input type="checkbox"/> Ski racing <input type="checkbox"/> Downhill skiing <input type="checkbox"/> Snowboarding <input type="checkbox"/> Special events <input type="checkbox"/> Tennis <input type="checkbox"/> Other: _____

\*\* OVER \*\*

<b>Strength &amp; Weakness Issues</b> <u>Comments:</u>		<input type="checkbox"/> Left side weak <input type="checkbox"/> Right side weak <input type="checkbox"/> Lower body weak <input type="checkbox"/> Upper body weak
<b>Visual Impairment</b> <u>Comments:</u>		<input type="checkbox"/> Left eye blind <input type="checkbox"/> Right eye blind <input type="checkbox"/> Peripheral blindness <input type="checkbox"/> Shadows only <input type="checkbox"/> Tunnel vision <input type="checkbox"/> Total blindness <input type="checkbox"/> Wear contacts <input type="checkbox"/> Wear Glasses
<b>Behavior/Emotion Issues</b> <u>Comments:</u>		<input type="checkbox"/> Angers easily <input type="checkbox"/> Frustrates easily <input type="checkbox"/> Impulsive <input type="checkbox"/> Mood swings <input type="checkbox"/> Perseveration <input type="checkbox"/> Physically loses control <input type="checkbox"/> Verbally loses control <input type="checkbox"/> Trigger words <input type="checkbox"/> Strategies to gain control: _____
<b>Communication</b> <u>Comments:</u>		<input type="checkbox"/> Non-verbal <input type="checkbox"/> Can follow 1-2 step directions <input type="checkbox"/> Others have trouble understanding me <input type="checkbox"/> Can make needs known <i>Difficulties:</i> <input type="checkbox"/> Communicating <input type="checkbox"/> Following directions <input type="checkbox"/> Learning new things <input type="checkbox"/> Remembering <i>Methods:</i> <input type="checkbox"/> Assistive symbols/signs <input type="checkbox"/> Cueing <input type="checkbox"/> Mayer Johnson <input type="checkbox"/> PECS/Picture exchange <input type="checkbox"/> Sentence Board <input type="checkbox"/> Sign Language <i>Bring System/Device:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Adaptive Equipment</b> <b>(What do you use?)</b> <u>Comments:</u>		