

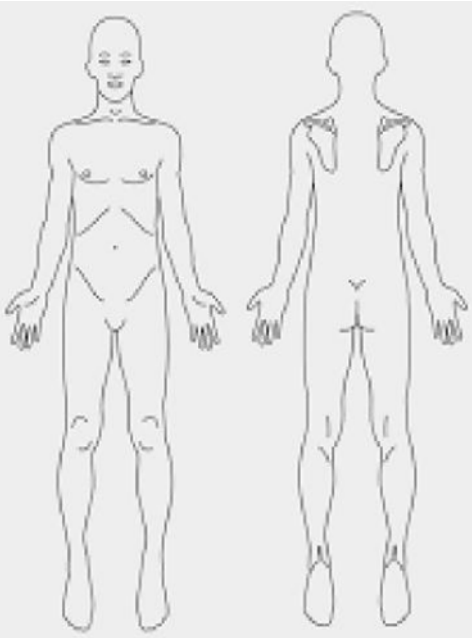


PROTECTED A (when completed)

PSP Reconditioning Program Intake Form

Date: _____

All information provided is voluntary. I understand that I am not obliged to divulge any medical information to any fitness provider. Initials: _____

PARTICIPANT INFORMATION	Rank and Name:	Service Number:	
	Telephone #:	Age:	Gender:
	Preferred Email:	Medical Providers: <input type="checkbox"/> MO/PA: <input type="checkbox"/> Physio: <input type="checkbox"/> Other:	
	Occupation/Trade:		
	Unit:		
	Supervisor Rank & Name:		
AREA(S) OF CONCERN	1 <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper Back <input type="checkbox"/> Lower Back <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Other: _____ _____		
	2 <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper Back <input type="checkbox"/> Lower Back <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Other: _____ _____		
ILLNESS / INJURY HISTORY			
	How and when did this occur?		

RESTRICTIONS	What activities has your medical provider told you to avoid? (including things not written on your chart) At Work: _____ At Home: _____ During Exercise: _____		
CURRENT PHYSICAL ACTIVITY	What exercises are you currently doing on a regular basis? Please list all. Physio-Prescribed Exercise: _____ Cardio Exercise: _____ Strength Exercise: _____		
AVAILABILITY	Please identify your availability, understanding that we may not always be able to accommodate your preferences. Morning <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri Time: _____ Afternoon <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri Time: _____		
PRIMARY GOAL	Please identify your primary goal. (e.g. FORCE result, weight management, complete daily activities pain-free, etc.)		
OTHER PROGRAMS & SERVICES	Are you interested in learning about the programs and services offered by: <input type="checkbox"/> Soldier On <input type="checkbox"/> Health Promotion <input type="checkbox"/> Recreation <input type="checkbox"/> Sports		
★For PSP use only ADDITIONAL NOTES	Comments/Notes: Assessments: Recommended Program:		
★For PSP use only INTAKE PROCESSED BY	Name:	Position:	
	Signature:	Date:	