



Physician Medical Release Form

To be completed by your Primary Care Provider or Neurologists

Date: ___/___/___

Your patient, _____, wishes to participate in Rock Steady Boxing (Non-Contact) exercise program. The activity will involve cardiovascular training (jumping rope, running, punching heavy bags), flexibility instruction (stretching, getting up and down on the floor), resistance training and core strengthening techniques. Participants can attend up to five classes per week that are 90 minutes in duration. Participants can reach up to 90 percent of their maximum heart rate.

Physician's Recommendation

I am not aware of any restrictions to participate in the exercise program.

I believe the patient can participate but would urge caution (Please Explain):

Patient should not engage in the following activities:

If your patient is taking medications that will effect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers or has no effect on the heart rate response during exercise):

Type of medication _____ Effect _____

Type of medication _____ Effect _____

Type of medication _____ Effect _____

Physician Completes

_____ (Patient's Name) has my approval to begin the Rock Steady Boxing program with the recommendations or restriction state above.

Physician's Signature _____ Phone _____



Member Information

Welcome to Rock Steady Boxing! We are please to welcome you into our program. To begin, please complete the following documents:

1. Member Information Form & Media Release
2. Physician's Medical Release
3. PDQ-39 Questionnaire
4. Personal Waiver and Release of Liability

Date ___/___/___

Name _____ DOB ___/___/___

Address _____

City _____ Zip Code _____

Home Phone _____

Cell Phone _____

Email _____

How did you hear about Rock Steady Boxing (please circle one)?

Referral / Media / Website Other: _____

Emergency Contact Information

Name: _____

Relationship to applicant: _____

Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email _____



Parkinson's Information

Date of diagnosis ___/___/___

Symptoms (Please give a brief description)

Tremors

Postural Instability

Vision Impairment

Shortness of Breath

Fatigue

Have you lost your balance or fallen in the past year? (Please circle) YES NO

Do you take medicine for Parkinson's Disease? If yes, please list:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Health Information

Do you have a heart condition or have you experienced any chest pains in the last 6 months?

(Please circle) YES NO

Do you take medicine for depression? YES NO

Have you been diagnosed with Diabetes? YES NO If YES, what type? _____

Do you feel dizzy or unsteady when making sudden changes in movement, such as bending down or turning quickly? YES NO

Do you use a walker or wheelchair, or do you need assistance walking? YES NO

Are you currently active with any physical activities? YES NO

If YES, what type of physical activity? _____



Do you feel unsteady when you are walking or climbing stairs? YES NO

Do you have difficulty sitting down or rising from a seated or lying position? YES NO

Do you have arthritis or problems with your bones and/or joints? YES NO

If YES, please explain _____

Have you been diagnosed with any other medical problems we should be aware of?

What do you wish to gain from joining Rock Steady Boxing?



PDQ-39 QUESTIONNAIRE

Please complete the following

Please tick one box for each question

Due to having Parkinson's disease, how often during the last month have you....

		Never	Occasionally	Sometimes	Often	Always or cannot do at all
1	Had difficulty doing the leisure activities which you would like to do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Had difficulty looking after your home, e.g. DIY, housework, cooking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Had difficulty carrying bags of shopping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Had problems walking half a mile?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Had problems walking 100 yards?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Had problems getting around the house as easily as you would like?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Had difficulty getting around in public?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Needed someone else to accompany you when you went out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Felt frightened or worried about falling over in public?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Been confined to the house more than you would like?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Had difficulty washing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Had difficulty dressing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Had problems doing up your shoe laces?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check that you have ticked one box for each question before going on to the next page

Due to having Parkinson's disease, how often during the last month have you....

Please tick one box for each question

		Never	Occasionally	Sometimes	Often	Always or cannot do at all
14	Had problems writing clearly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Had difficulty cutting up your food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Had difficulty holding a drink without spilling it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Felt depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Felt isolated and lonely?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Felt weepy or tearful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Felt angry or bitter?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	Felt anxious?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	Felt worried about your future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	Felt you had to conceal your Parkinson's from people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	Avoided situations which involve eating or drinking in public?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25	Felt embarrassed in public due to having Parkinson's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	Felt worried by other people's reaction to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	Had problems with your close personal relationships?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28	Lacked support in the ways you need from your spouse or partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>If you do not have a spouse or partner tick here</i>		<input type="checkbox"/>			
29	Lacked support in the ways you need from your family or close friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check that you have ticked one box for each question before going on to the next page

Due to having Parkinson's disease, how often during the last month have you....

Please tick one box for each question

		Never	Occasionally	Sometimes	Often	Always
30	Unexpectedly fallen asleep during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31	Had problems with your concentration, e.g. when reading or watching TV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32	Felt your memory was bad?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33	Had distressing dreams or hallucinations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34	Had difficulty with your speech?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35	Felt unable to communicate with people properly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36	Felt ignored by people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37	Had painful muscle cramps or spasms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38	Had aches and pains in your joints or body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39	Felt unpleasantly hot or cold?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check that you have ticked one box for each question before going on to the next page

Thank you for completing the PDQ 39 questionnaire



Waiver and Release of Liability

Rock Steady Boxing, Inc. (hereinafter, "RSB")

1. I understand the nature of Rock Steady Boxing, Inc.'s activities, and my physical condition and capabilities, and I believe that I am physically capable of participating in such activity. I further acknowledge that I am aware that the activity may be conducted in facilities open to the public or members of the public and/or employees of another corporate entity or entities, during the activity. I further agree and warrant that any time, if I believe the condition to be unsafe, I reserve the right, without penalty, financial or otherwise, to immediately discontinue further participation in the activity and bring such condition to the attention of the management of RSB.

2. I FULLY UNDERSTAND that (a) the activities at RSB involve risk and dangers of **SERIOUS BODILY INJURY**, including permanent disability, paralysis and death: ("Risks"); (b) these Risks and dangers may be caused by me or by the actions or inactions of others participating in the activity, the conditions under which the activity takes place, or **THE NEGLIGENCE OF THE "RELEASES" NAMES BELOW**; (c) there may be other risks and social and economical losses with know to me or not readily foreseeable at this time, and I **FULLY ACCEPT AND ASSUME ALL SUCH RISKS AND ALL RESPONSIBILITY FOR LOSSES, COSTS, AND DAMAGES** incurred as a result of my participation in these activities.

3. I HEREBY RELEASE, DISCHARGE, AND COVENANT NOT TO SUE, AND AGREE TO INDEMNIFY AND SAVE AND HOLD HARMLESS RSB AND THE GREENWOOD SENIOR CITIZEN'S CENTER, INC and its clubs and their respective administrators, directors, agents, officers, volunteers, and employees, other participants, any sponsors, advertisers, and if applicable, owners and lessors of premises on which the activities take place (each considered one the "Releases" herein) from all liability, claims, demands, losses or damages on my account caused or alleged to be caused in whole or in part by the negligence of the "Releases" or otherwise, including negligent rescue operations and further agree that if, despite the release, I or anyone on my behalf makes a claim against any of the Releasees, I will be responsible for the payment to any or all of the releasees harmed by such assertion of a waived claim, or any expenses arising from my assertion or waived or causes of action, including but not limited to reasonable attorney fees and court costs.

4. I certify that I have no injuries to my hands, whether fractures, broken bones, or otherwise, within three Months preceding the dates of completion of this entry form, and have no injuries to the head, concussion, Headaches or fainting spells, and I should I experience any of these injuries and/or conditions in the future, I will immediately notify the officials of these events and/or conditions, and immediately cease my participation In said events and activities.

5. I hereby further agree that this agreement may not be modified orally, and a waiver of any provision shall not be construed as a modification of any other provision herein or as consent to any subsequent waiver or modification. Every term and provision of this agreement is intended to be severable, if any one or more provision is found to be unenforceable or invalid, said provision shall not affect the other terms and provisions, which shall remain binding and enforceable.

Printed Name of Applicant

Signature of Applicant

___/___/_____
Date