Intake Evaluation

New Members

- Member Information
- Intake Questionnaire
- Permission to Contact Health Professionals / Providers
- Guidelines and Policies
- Liability Waiver

Member Information		
Member name:		
Birth date:	Age:	Sex:
Home address:		
City:	State:	Zip:
School:		
Grade:	IEP: Yes No	Date of last IEP:
Parent / Guardian name(s):		
Phone(s):	E-mail:	

In Case of Emergency	
Emergency contact:	
Number(s):	Relationship to member:
Emergency contact:	
Number(s):	Relationship to member:

Individuals Authorized to Pick Up Member (other than parent or guardian)	
Name:	Phone:
Name:	Phone:

Medical	
Does the member have a history of seizures? Yes No	
If yes, please explain:	
Does the member have any allergies? Yes No	Does he/she require an Epipen? Yes No
If yes, please explain:	
Does the member have asthma? Yes No	Does he/she use a preventative or rescue inhaler? Yes No
If yes, please explain:	

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Intake Evaluation

Intake Questionnaire

1. Would the member 1st prefer hugs, high fives or no contact as an initial greeting when he/she walks into the center?

_____

_____

2. Please list current services, including extra-curricular activities (OT, Speech, 1:1 Aid, Resource room, Therapists, etc.) and names of service professionals / providers:

_____

_____

3. Please list any sensitivities / stressors (textures, lighting, over talking, physical contact, scent, volume and type of music, etc.) that may create a feeling of panic for the member. How have these situations been handled in the past?

_____

_____

4. Will the member feel comfortable if a trainer or class instructor makes physical contact with him / her as part of 1-on-1 training or class instruction (correcting form, assisting with an exercise, etc.)?

_____

_____

5. Does the member utilize an augmentative / assistive means to communicate (sign language, picture communication, etc.)? If yes, please explain. How does he/she express his/her emotions (anger, frustration, happiness, etc.)?

_____

_____

6. Does the member need help with using the restroom? If yes, please explain.

_____

_____

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7. Does the member take any medications that would prevent him/her from participating in certain types of activities at the center? If yes, please explain.

_____

_____

8. Does the member have any medical conditions that would prevent him/her from participating in certain types of activities at the gym? If yes, please explain.

_____

_____

9. What techniques work best with the member to facilitate transitions from one activity to the next?

_____

_____

10. What techniques work best to calm the member?

_____

_____

11. What techniques work the best to instruct the member?

_____

_____

12. What motivates the member?

_____

_____

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13. Does the member seek or require sensory stimulation (physical pressure, etc.)? If yes, please explain.

_____

_____

14. Is there a specific behavior plan for the member? If yes, please explain or provide documentation.

_____

_____

15. Does the member have any physical limitations? If yes, please explain.

_____

_____

16. Please list the member's preferred fitness activities:

_____

_____

17. What supports are required in order for the member to be successful during preferred activities?

_____

_____

18. What fitness activities do you think the member would like to master? Which would you like the member to master?

_____

_____

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19. What do you think the member would like in a gym experience (social, circuits, classes, one-on-one training, weights, cardio machines, etc.)?

_____

_____

20. Are there functional goals that you would like added to the member's Individual Fitness Program – IFP (catching or throwing a ball, riding a bike, etc.)?

_____

_____

21. Would the member prefer to work with a male or female trainer?

_____

_____

22. Is there anything else you would like us to know about the member?

_____

_____

_____

23. Who referred you or how did you hear about the ASD Fitness Center?

_____

Please place an "X" in front of the following statement if you agree with it:

____ To the best of my knowledge, the answers to the is questionnaire are accurate

Please place an "X" below if you wish to add additional information regarding the member's health:

____ I would like to add the following documentation_____

_____

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Permission to Contact Health Professionals / Providers

Patient Name: _____ Date of Birth: _____

The person named above is or has been a patient of:		
Name:	Facility:	Phone:
Service provided to patient:		
Date(s) of service:		
Name:	Facility:	Phone:
Service provided to patient:		
Date(s) of service:		
Name:	Facility:	Phone:
Service provided to patient:		
Date(s) of service:		
Name:	Facility:	Phone:
Service provided to patient:		
Date(s) of service:		
Name:	Facility:	Phone:
Service provided to patient:		
Date(s) of service:		
Name:	Facility:	Phone:
Service provided to patient:		
Date(s) of service:		

I have read the above waiver and agreement and have fully understood its contents. By signing below, I fully agree to members of the ASD Fitness Center staff to contact listed individuals.

Member's name printed: _____

Member / Guardian's signature: _____ Date: _____

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Guidelines and Policies

A critical aspect of our approach is the structure and continuity established within and between sessions and classes. In keeping with our commitment to consistency, we as that you follow some simple guidelines:

- Please do not come more than ten minutes early for any scheduled programs (i.e., training or group classes. Our staff may still be working with their previous appointments. This will help us keep a structured environment for all members.

- Please do not bring food for the member to eat in the studio before or after sessions. We are a peanut and tree nut free environment and do not want to risk any potential allergic reactions. Only water will be allowed to be consumed in our workout areas, unless medically necessary.

- Anyone other than yourself who will be picking up the member must be listed as authorized to pick up the member and will be required to show proper identification.

Although we believe that this high degree of structure is essential to our work with the member, we want you to feel completely at home in the waiting area when you bring the member to his / her session or class. You are welcome to read, watch TV, enjoy a cup of coffee or tea, take a peaceful rest, or treat yourself to a salon or spa service across the street or next door.

Guardian's signature: _____ Date: _____

Liability Waiver

The following is a release and liability waiver.

1. I understand that the ASD Fitness Center incorporates physical exercise, and that there is always an inherent risk when participating in physical activities. I agree to let the instructor know of any physical limitations the member might have, or any physical activities I do not wish the member to participate in. _____ (initial)

2. I hereby release the ASD Fitness Center for any injuries the member may sustain as a result of participation in an activities at the ASD Fitness Center or its programs. _____ (initial)

I have read the above waiver and agreement and have fully understood its contents. By signing below, I am fully agreeing to all of the above statements.

Member's name printed: _____

Member / Guardian's signature: _____ Date: _____

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