Participant Form

(775) 333-7765 Reno.Gov/Adaptive RenoAdaptive @Reno.Adaptive

RENO ADAPTIVE

CITY OF RENO

City of Reno Military Sports Camp

PARTICIPANT FORM

Contact Information

Name of Participant: _____

Date of Birth: _____ Age: _____

Current Mailing Address:

_____

City, State, Zip:

_____

Permanent Address (if different from above):

_____

City, State, Zip:

_____

Home Number: _____ Cell Number: _____

E-mail Address: _____

Contact Preference: ☐ E-mail ☐ U.S. Mail ☐ Do Not Solicit

Height: _____ Weight: _____ Hip Width (for wheelchair users): _____

Gender: ☐ Male ☐ Female T-Shirt Size: _____ Glove size: _____

Emergency Contact	Relationship	Home Phone	Cell Phone

Military Service Information

Status in the U.S. Armed Forces: ☐ Active Duty ☐ Veteran ☐ Reservist

Branch of Service: _____ Years of Active Duty: _____

Date of Separation from Active Duty: _____ Rank: _____

Deployment/Tour of Duty Experience:

_____

_____

_____

_____

_____

Disability/Medical Information

What is Your Disability?

Date of onset: _____

#	Medications	What are they for?	Any change to your medications in the last 3 months?
1			
2			
3			
4			
5			

Do you have seizures? ☐ Yes ☐ No If yes, date of last seizure _____ and type _____

Frequency of seizures: _____

List any allergies you may have:

Do you have any diet restrictions? ☐ Yes ☐ No If yes, please describe:

Are any of your body parts susceptible to cold, heat and/or impact? ☐ Yes ☐ No If yes, please list:

Do you have cardiac problems? ☐ Yes ☐ No If yes, please describe:

Do you experience pain? ☐ Yes ☐ No Location(s) of Pain:

Percentage of time you are in pain: On a scale of 1-10, what level of pain are you in?

Ability to Speak: ☐ Intact ☐ Impaired
Hearing: ☐ Intact ☐ Impaired
Vision: ☐ Intact ☐ Impaired

Do you have decreased strength in your upper extremities (arms)? ☐ Yes ☐ No If yes, what side?

Will you need any type of adaptation device to hold objects (i.e. paddle, etc.)?

Do you have any upper extremity limitation that may effect your activity participation? ☐ Yes ☐ No

Do you have decreased sensation in either one of your arms/hands? ☐ Yes ☐ No If yes, where and what extent?

Combat Stress: ☐ Yes ☐ No If yes, please complete

Do you have panic attacks?	☐ Yes	☐ No
Do you have flashbacks?	☐ Yes	☐ No
Are you sensitive to loud noises?	☐ Yes	☐ No
Do crowds make you feel anxious?	☐ Yes	☐ No
Do you get angry easily?	☐ Yes	☐ No
Are you hyper-vigilant?	☐ Yes	☐ No
Do you isolate yourself?	☐ Yes	☐ No
Do you get anxious easily?	☐ Yes	☐ No

How do you handle stress?

How can we best support you should you become anxious, fearful, angry, etc.?

Amputation: ☐ Yes ☐ No If yes, please complete

Status of Injury: ☐ Primary Disability ☐ Secondary Condition

Date of Amputation: _____ Level of Amputation: _____

Please describe your means of mobility (i.e. prosthesis, wheelchair, none, etc.):

If you have prosthesis, will you be using it while taking part in our program? ☐ Yes ☐ No

(Please note: we will not held responsible if the prosthesis becomes damaged or broken while participating in our programs)

Please list ALL safety precautions you take to protect the amputated limb against falls, etc.

Please describe what devices/methods you use to prevent skin breakdown or pressure ulcers:

Traumatic Brain Injury (TBI): ☐ Yes ☐ No If yes, please complete:

Status of Injury: ☐ Primary Disability ☐ Secondary Condition

Severity of Injury: ☐ Mild ☐ Moderate ☐ Severe

Has your TBI affected you in any of the following ways?

Short-term memory impairment?	☐ Yes	☐ No
Decreased attention spam?	☐ Yes	☐ No
Problem-solving difficulties?	☐ Yes	☐ No
Inability to concentrate?	☐ Yes	☐ No
Impulsive/decrease ability to filter what I say/do?	☐ Yes	☐ No
Decreased balance?	☐ Yes	☐ No
Vestibular impairment?	☐ Yes	☐ No
Do you get dizzy?	☐ Yes	☐ No
Do you get motion sickness?	☐ Yes	☐ No
Do you have headaches?	☐ Yes	☐ No

How often do they occur? _____

What triggers your headaches? _____

On a scale from 1 to 10, how severe are your headaches? _____

How do you treat your headaches? ☐ Medication ☐ Rest ☐ Other:

_____

Mobility

Are you able to walk? ☐ Yes ☐ No If yes, how far of distance? _____

What percentage of the day do you walk? ☐ 25% ☐ 50% ☐ 75% ☐ Full-time walking ability

Are you limited by fatigue? Pain? Skin Issues? _____

What type of terrain are you able to walk on? ☐ Flat ☐ Incline/Decline ☐ Rocky/Uneven ☐ All

Do you use a mobility device? ☐ Yes ☐ No

If yes, which device do you use? ☐ Wheelchair ☐ Walker ☐ Cane ☐ Crutches ☐ Prosthetic ☐ Orthotic ☐ Other:

_____

_____

If using a wheelchair, what percentage of a day do you use a wheelchair? ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ Full-time Wheelchair Use

Are you independent in your transfers? ☐ Yes ☐ No

If not, what level of assistance do you need? ☐ Minimal (contact guard) ☐ Moderate (pivot transfer) ☐ Maximum (2 person lift)

General Information

Please describe yourself socially (interest/activities)

Please list three goals that you would like to achieve while participating in this activity:

1. Social

2. Physical

3. Recreational

Please identify future activities/recreation you would like to participate in:

Please describe additional information that will assist us in providing the best possible experience for you:

Water Safety

Can you Swim? ☐ Yes ☐ No

Can you turn from a face down to a face up position in the water (water safe)? ☐ Yes ☐ No

Can you grip or hold a paddle or handle? ☐ Yes ☐ No ☐ Right Hand Only ☐ Left Hand Only

Do you have any unusual reactions to cold water and/or sun exposure? ☐ Yes ☐ No

If yes, please explain:

Have you been cleared to be in the water? ☐ Shower ☐ Submerged