

Boxer Name: _____



FIGHTING BACK AGAINST PARKINSON'S

Member Information

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

1. Member Information Form
2. PDQ-39 Questionnaire
3. Personal Waiver and Release of Liability

Date ____/____/____

Name _____ DOB ____/____/____

Address _____

City _____ Zip Code _____

Home phone _____ Cell phone _____

Business Phone _____ Email _____

How did you hear about Rock Steady (circle)? Referral / Media /Website / Other _____

Education Level: _____

Occupation: _____

Emergency Contact Information

Name _____ Email: _____

Relationship to applicant _____

Address _____

City _____ Zip Code _____

*This proprietary information has been prepared by RSB Headquarters for use by RSB Affiliates and boxers.
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Parkinson's Information:

Estimated date of diagnosis ____/____/____

Which symptoms are you experiencing in your daily life? (Check all that apply)

- Tremors - if yes, which side is most affected? RIGHT LEFT BOTH
- Difficulty with balance in the last year
- Feel dizzy or unsteady with sudden movements
- Difficulty with swallowing or choking
- Difficulty being heard or understood when speaking
- Vision impairment
- Difficulty concentrating or staying focused
- Slowness of thought processing information
- Difficulty with memory
- Fatigue
- Difficulty sleeping
- Depression
- Do you take medicine for Parkinson's? If yes, please list:

Exercise History:

1. Do you **currently** participate in “regular physical activity”? Yes/No

(Per ACSM Guidelines, defined as participating with planned, structured physical activity at least 30 minutes at moderate intensity on at least 3 days/week for the last 3 months).

2. If No, have you **previously** participated in regular physical activity? Yes/No

3. Describe what physical exercise you are currently doing OR have done:

(Frequency, Intensity, Type, Time) _____

AHA/ACSM Health/Fitness Facility

Pre-Participation Screening Questionnaire

History: (check all that apply)



- A heart attack
- Heart surgery
- Cardiac catheterization coronary
- Angioplasty (PTCA)
- Pacemaker/implantable cardiac defibrillator
- Heart rhythm disturbance (such as atrial fibrillation)
- Heart valve disease (or surgery)
- Congestive heart failure
- Heart transplantation
- Congenital heart condition
- Other heart condition (specify) _____

Symptoms:

- You experience chest, neck, jaw or arm pain at rest or with exertion
- You experience shortness of breath at rest or with mild exertion
- You experience dizziness or syncope (fainting)
- You have trouble breathing when lying flat (orthopnea)
- You take heart medications

Other health issues:

- You have deep brain stimulator
- You have diabetes
- You have asthma or other lung disease
- You have burning or cramping sensation in your lower legs when walking short distances
- You have musculoskeletal problems that limit your physical activity: (list)

- You have concerns about the safety of exercise
- You take prescription medication(s)
- You are pregnant

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(FOR OFFICE USE ONLY)

Notes and questions for test administrator

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

Have you had any falls in the past year? (Defined as any unintentional event in which any part of the body comes in contact with the ground or lower surface). Describe.

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

Do you have questions or concerns about the program before we get started

This boxer may benefit from a referral or screening from the following healthcare provider: Movement Disorder Specialist PT OT SLP Counselor.

Information provided to boxer/Caregiver Yes No

Boxer Name: _____

(Administrator to explain Media Release)

Media Release

I _____ (member name) allow Rock Steady Boxing to publish or broadcast my image/likeness and/or name for promotional purposes associated with Rock Steady Boxing.

Signature _____ Date _____