



## Member Information

**Welcome** to Rock Steady Boxing! We are pleased to welcome you into our program.

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 \_\_\_\_\_

## Emergency Contact Information

Name \_\_\_\_\_

Relationship to applicant \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Email \_\_\_\_\_

## Parkinson's Information:

Estimated date of diagnosis \_\_\_\_/\_\_\_\_/\_\_\_\_

Dominant hand: **Right** \_\_\_\_\_ **Left:** \_\_\_\_\_

Which symptoms are you experiencing? (check all that apply)

- ☐ Tremors - if yes, which side is most affected? ☐ RIGHT ☐ LEFT ☐ BOTH
- ☐ Postural changes
- ☐ Loss of balance in the last year
- ☐ Slowness of movement
- ☐ Vision impairment
- ☐ Difficulty concentrating or staying focused
- ☐ Fatigue
- ☐ Depression
- ☐ Do you take medicine for Parkinson's? If yes, please list:  
\_\_\_\_\_

**Other Health Questions** Do you: (check all that apply)

- ☐ Use a walker, wheelchair or other assistive device
- ☐ Have Deep Brain Stimulation (DBS)
- ☐ Feel dizzy or unsteady with sudden movements
- ☐ Have difficulty getting down or rising from a seated or lying position

**History:** check all that apply if you have had:

- ☐ A heart attack
- ☐ Heart surgery
- ☐ Cardiac catheterization coronary
- ☐ Angioplasty (PTCA)
- ☐ Pacemaker/implantable cardiac defibrillator
- ☐ Rhythm disturbance
- ☐ Heart valve disease
- ☐ Heart failure
- ☐ Heart transplantation
- ☐ Congenital heart disease
- ☐ Other heart condition (specify) \_\_\_\_\_

**Symptoms:**

- ☐ You experience chest discomfort with exertion
- ☐ You experience unreasonable breathlessness
- ☐ You experience dizziness, fainting or blackouts
- ☐ You take heart medications

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Other health issues:

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

What symptoms of Parkinson's are you experiencing in your daily life?

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

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

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

Additional notes: \_\_\_\_\_

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(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 \_\_\_\_\_

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