



FIGHTING BACK AGAINST PARKINSON'S

**Member Information**

Welcome to Strong Steps! 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 Strong Steps (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 \_\_\_\_/\_\_\_\_/\_\_\_\_

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

## Health/Fitness Facility Pre-Participation Screening Questionnaire

History: (check all that apply)

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

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

(FOR OFFICE USE ONLY)

**Notes and questions for test administrator**

**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 Strong Steps?**

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

Additional administrator notes:

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(Administrator to explain Media Release)

**Media Release**

I \_\_\_\_\_ (member name) allow the JCC to publish or broadcast my image/likeness and/or name for promotional purposes associated with Strong Steps.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Physician Medical Release Form**

TO BE COMPLETED BY YOUR PRIMARY CARE PROVIDER

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Doctor's Name: \_\_\_\_\_

Your patient, \_\_\_\_\_, DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ wishes to participate in the JFIT Thrive Strong Steps (NON-CONTACT) exercise program for people with Parkinson's disease.

Our goal is to help your patient have a better quality of life through fitness and socialization. The activities may involve cardiovascular training, jumping rope, walking/running, punching heavy bags), flexibility instruction (stretching, getting up and down on the floor), resistance training and core strengthening techniques. Safety and modifications for various levels of fitness and disease progression are considered.

**PHYSICIAN'S RECOMMENDATION**

- I am not aware of any restrictions to participate in this 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 affect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers or has no effect on 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 **JFIT Thrive Strong Steps** exercise program with the recommendations or restrictions stated above.

Printed name \_\_\_\_\_

Phone \_\_\_\_\_

Signature \_\_\_\_\_

**RETURN TO**

Name  
Address  
Phone/Fax  
Email

# 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, <b>housework, cooking?</b>	<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 <b>around the house as easily</b> 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 <b>accompany you when you</b> went out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Felt frightened or worried about falling <i>over</i> 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 <b>your shoe laces?</b>	<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"/>



**WAIVER & RELEASE OF LIABILITY**

Marcia and Bruce Sklare JFIT Thrive Strong Steps. (hereinafter, "Strong Steps"):

The individual named below (referred to as "I" or "me") desires to participate in the Strong Steps program (the "Activity"). As lawful consideration for the intangible value that I will gain by participating in the Activity, I agree to all the terms and conditions set forth in this Waiver and Release of Liability (this "Release").

I am aware and understand the nature of the Activity, 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 any 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 JCC management.

**I AM AWARE AND FULLY UNDERSTAND** that (a) the Activity involve risks 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 "RELEASEES" NAMES BELOW**; (c) there may be other risks and social and economic losses either known 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.

**I ACKNOWLEDGE THAT I AM VOLUNTARILY PARTICIPATING IN THE ACTIVITY WITH KNOWLEDGE OF THE DANGER INVOLVED AND HEREBY AGREE TO ACCEPT AND ASSUME ANY AND ALL RISKS OF INJURY, DEATH, OR PROPERTY DAMAGE, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEES OR OTHERWISE.**

**I HEREBY RELEASE, DISCHARGE, COVENANT NOT TO SUE, AND AGREE TO INDEMNIFY AND SAVE AND HOLD HARMLESS** the JCC and its 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 of the "Releasees" 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 "Releasees" or otherwise, including negligent rescue operations and further agree that if, despite this 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 of waived claims or causes of action, including but not limited to reasonable attorney fees and court costs.

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 provision, which shall remain binding and enforceable. All matters arising out of or relating to this Release shall be governed by and construed in accordance with the internal laws of the State of Indiana without giving effect to any choice or conflict of law provision or rule (whether of the State of Indiana or any other jurisdiction). Any claim or cause of action arising under this Release may be brought only in the federal and state courts located in Marion County, Indiana and I hereby consent to the exclusive jurisdiction of such courts.

**BY SIGNING, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTOOD ALL OF THE TERMS OF THIS AGREEMENT AND THAT I AM VOLUNTARILY GIVING UP SUBSTANTIAL LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE THE RELEASEES.**

\_\_\_\_\_  
Printed Name of Applicant

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature of Applicant