BIG for LIFE®

Thank you for your interest in BIG for LIFE, an exercise class for people who have already completed the therapeutic LSVT BIG® treatment protocol with an LSVT BIG Certified physical or occupational therapy professional.

Please complete the following form which will ask for contact information and basic health information which we will use to help ensure your safety when participating in the BIG for LIFE exercise classes.

If you have any questions about BIG for LIFE, please contact your local BIG for LIFE leader, Amy Nichols at amy.nichols@olathehealth.org, or (913) 791-4325 x2.

For additional general information on LSVT BIG and BIG for LIFE, contact LSVT Global, Inc. at info@lsvtglobal.com or 1-888-438-5788. For specifics regarding your local class, please contact your BIG for LIFE leader at the phone/email listed above.

Name:_____

Phone Number: _____

Email Address: _____

Date of Birth:_____

Diagnosis: _____

Have you received LSVT BIG per protocol? (16 sessions; 4 times/week for 4 wks)

Yes **No** **I Don't Know**

How often are you currently performing your LSVT BIG home program?

_____

Have you fallen in the last 3 months? **YES** **NO**

Do you have any balance concerns? **YES** **NO**

Do you ever use an assistive device (e.g. cane, walker)?

YES **NO**

If so, what type of assistive device(s) and when do you use it?

_____

At home, do you ever need supervision or physical assistance with:

Walking **YES** **NO**

Performing any your daily activities **YES** **NO**

Practicing the LSVT BIG Exercises **YES** **NO**

Which activities or exercises do you need assistance with?

_____

_____

_____

Do you have any medical conditions which could affect your ability to safely participate in exercise?

Diabetes **YES** **NO**

If so, do you carry medication? **YES** **NO**

Heart issues **YES** **NO**

If so, explain. _____

History of seizures **YES** **NO**

If so, when was your last one? _____

History of fainting or dizziness due to low blood pressure

YES **NO**

OTHER MEDICAL CONDITIONS

_____

_____

Other important information you would like the instructor to know:

_____

_____

_____

_____

Emergency Contact Name:_____

Relationship: _____ Phone Number:_____

Alternative Number: _____

Referring Physician: _____

Phone number: _____

Facility/Organization:_____