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HEALTH APPRAISAL QUESTIONNAIRE **FOR PHYSICAL ACTIVITY**

- Information for the physician -

Viomax is a non-profit organization that offers various programs of physical activities, to people who live with or without physical disabilities. The activities take place at the facilities of the Centre de Réadaptation de Lucie Bruneau when not in use by the Centre. Viomax is open from 12:00 pm to 1:30 pm, 4:30 pm to 9:30 pm during week-days, and also on the weekends. The facilities of CRLB consist of a gymnasium, a heated pool (large basin (96 F), small bassin (88 F)) as well as a physical conditioning gym with equipment is adapted for wheelchair users.

Program participants are evaluated by an employee of Viomax who is studying, or who has obtained, a university degree in Physical Education, and has been trained to work with people who have a physical disability. After an evaluation, an adapted physical activity program is prescribed. Activities are supervised and followed-up by a physical educator.

The person who is using this questionnaire has made a request to become a member of our organization so that they can benefit from physical activity. With the goal of ensuring that we continue to offer quality services, we ask that you please fill out the following questionnaire.

Thank you for your co-operation.

IDENTIFICATION

NAME : _____ FIRST NAME: _____

COMPLETE ADDRESS: _____

_____ POSTAL CODE _____

DATE OF BIRTH: _____ / _____ / _____ TEL.: () _____
day month year

MAIN DIAGNOSIS

SECONDARY DIAGNOSIS (TRANSMISSIBLE PATHOLOGY)

MEDICAL HISTORY : In the past, has the patient suffered any of the following

- | | | | | |
|--|---|---------------------------------------|---|---|
| <input type="checkbox"/> Cardio-vascular | <input type="checkbox"/> Muscular | <input type="checkbox"/> Bone-related | <input type="checkbox"/> Pulmonary | <input type="checkbox"/> Articular |
| <input type="checkbox"/> Dizzyspells | <input type="checkbox"/> Blood plessure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous system | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabete | <input type="checkbox"/> Fainting | <input type="checkbox"/> Eyesight | <input type="checkbox"/> Infections | <input type="checkbox"/> Hearing/auditive |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Allergies | | |

WHAT FUNCTIONAL LIMITATIONS ARE RESULTING FROM THIS (THESE) DIAGNOSIS?

IN YOUR OPINION, ARE THERE ANY CONDITIONS WICH MAY LIMIT THIS PERSON'S PARTICIPATION IN AN ADAPTED PHYSICAL ACTIVITY PROGRAM ?

yes _____ no _____

IF YES, PLEASE INDICATE WHICH LIMITATIONS?

IS THE PATIENT TAKING ANY MEDICATION THAT COULD AFFECT HIS PHYSICAL TRAINING?

COMMENTS:

DOCTOR IDENTIFICATION

Date: _____

NAME: _____

Address: _____ Telephone: () _____

Signature: _____ Practice number: _____