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285 Cummer Avenue
Toronto, ON M2M 2G1

www.stjohnsrehab.com

Active Living Program
Participation Application Form

Date: ________________________

Name: ____________________________ **Age:** ________

Address: ____

Home Phone: _________________________ **Work Phone**: ________________________

Emergency Contact Phone: ___________ Name: ________________________

Reason for taking program (circle one): Post-rehab/Arthritic care/General conditioning/ Fall prevention/Other (Please specify) _________________________________

Which sessions are you applying for?
1st choice:
2nd choice:
3rd choice:

How did you become aware of this Program? ________________________

Please indicate if you have experienced any of the following conditions (circle): ***If applicable, explain***

Problems with bladder/bowel control	**Yes/No**
Seizures – epileptic	**Yes/No**
Fainting spells	**Yes/No**
Problems with blood pressure	**Yes/No**
If yes, ***High blood pressure*** o	
Low blood pressure o	
Heart condition (e.g. angina)	**Yes/No**
Diabetes	**Yes/No**
If yes, ***do you require insulin?***	**Yes/No**
Breathing Problems (e.g. asthma)	**Yes/No**
Deafness	**Yes/No**
Limited vision	**Yes/No**
Poor balance	**Yes/No**
Independently Mobile	**Yes/No**

Other medical conditions or symptoms that may affect participation in the Program**: Yes/No**
If yes, ***explain:*** ______________________________________

My Doctor is: ______________________ **Dr.'s Telephone No.** _______________

Please send your completed application, your doctor's referral along with your cheque made payable to St. John's Rehab Hospital. Send to Outpatient Services, at the address listed above.