UMASS LOWELL

# General Intake Form

## Personal Information

**Participant Name:**_____ **Date of Birth:**_____

**Address:**_____

_____

**Phone:**_____**E-mail:**_____

**Gender:**
Male Female

**Age:** _____

**Ethnicity:**
Black/African American
American Indian/Alaskan Native
Asian/Pacific Islander
Caucasian
Hispanic or Latino
Other: _____

## Medical History

**Do you have any medical conditions? (Please list all)**

_____
_____
_____
_____
_____

**Have you had any surgeries or hospitalizations in the past year?** Yes No

**If yes, please describe:**_____
_____
_____
_____

**Do you have any joint replacements, such as hip or knee replacements?**
Yes No

**If yes, what joint was replaced and when?**_____

_____

**Have you previously suffered a traumatic brain injury?**
Yes No

**If yes, how long ago?**_____

**If yes, please describe:**_____

**Do you suffer from dizziness or vertigo?**
Yes No

**If yes, please describe:**_____

**Do you suffer from motion sickness or have migraines?**
Yes No

**If yes, please describe:**_____

**Do you suffer from any other ailments (not listed above) that adversely impact your balance?**
Yes No

**If yes, please describe:**_____

**Are you currently taking any medications, in particular, those that cause a loss of balance and/or dizziness?**
Yes No

**If yes, please list the medications:**_____

_____

**Physical Abilities**

**Have you previously suffered from a fall-related injury?**
Yes No

**If yes, how many times and how long ago?**_____

**Please describe:**_____

**Do you currently exercise?**
Yes No

**If yes, how often and which activities?**_____

_____

**If no, when is the last time you attempted to exercise/elevate your heart rate?**

_____

**Do you have any physical disabilities or limitations that could limit your ability to engage in physical activities or VR-based training? (Please specify)**

_____
_____

**Describe your fitness level on a scale of 1-10, with 10 being the most fit and 1 being the least fit** _____

**Visual Abilities**

**Do you wear glasses or contact lenses?**
Yes No
**If yes, please describe** _____

**Do you have a loss of vision, but do not wear glasses or contact lenses?**
Yes No
**If yes, please describe**_____

**Cognitive Abilities**

**Do you have any cognitive impairments or limitations that could affect your ability to understand instructions or participate in the study activities?**

Yes No

**Hearing Abilities**

**Do you have any hearing impairments that could limit your ability to participate in the VR-based training program?**

Yes No

**Emergency Contact**

**Name: _____**

**Relationship: _____**

**Phone Number:_____**

**Informed Consent**

**Have you read and understood the information provided about the study?**

Yes No

**Do you have any questions or concerns about the study?**

Yes No

**If yes, please state_____**

**Thank you for completing this intake form. Please note that your participation is voluntary, and you may withdraw at any time.**