Adaptive Travel
Phone: (604) 679-7411 Fax: (866) 903-3383
E-mail: info@adaptivetravelling.com
Web: Adaptivetravelling.com
Mail: Box 25141 Mission Park P.O. Kelowna, BC, Canada V1W 3Y7

"TOGETHER WE MAKE A DIFFERENCE"

Multiday Adventure Questionnaire

The following information is used to provide Adaptive Travel personnel with an assessment of each person embarking on an adventure (participants, family members, care aids etc.) Information is only used for safety and emergency purposes. This information is confidential. Please be as detailed as possible.

It is your responsibility to update Adaptive Travel personnel of changes to information on this form that occur after filling it out and before embarking on your adventure.

Today's date (d/m/y) ____/____/_____

Name: Last: _____ First: _____Middle: _____Age: _____

Date of birth: (dd/mm/yy) _____ /_____ /_____ Gender: **M** **F** Height: _____Weight: _____

Address: (street, city, prov, post code)

_____

Phone: Home: _____Cell: _____Other: _____Email: _____

PERSONAL CARE

Does the individual for whom this form is for need assistance with personal care? Circle one: **YES** **NO**

_____

If **YES** to above question, will the person for whom this form is for be bringing a personal care assistant on their trip **OR** do they need assistance finding one?

_____

SUPPORT CONTACT

If applicable and different from above please indicate who the support contact is:

Name: _____Relationship: _____

Phone: Home: _____Cell: _____Other: _____ Email_____

EMERGENCY CONTACT: (must be someone not embarking on trip)

1. Name: _____ Relationship: _____

Phone: Home: _____Cell: _____Other: _____

2. Name: _____ Relationship: _____

Phone: Home: _____Cell: _____Other: _____

BC MEDICAL NUMBER: (in case of emergency) _____

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ALLERGIES: (food, medicines, insects, plants, chemicals) **Note ANY and ALL**. explain signs, symptoms & treatment

_____

_____

DIETAIRY RESTRICTIONS:

_____

_____

Please check all that apply this list is not complete. Please specify any and all condition(s) or challenges you have. Describe in the section that follows.

- ☐ **Sensory system:** Deaf**,** partially deaf**,** blind, partially blind, visual neglect, depth perception, colour blindness, etc.
- ☐ **Nervous system:** Cerebral Palsy, paraplegia, quadriplegia, Hemiparesis, seizures, neuropathy, spasticity etc.
- ☐ **Circulatory system:** High or low blood pressure**,** irregular heartbeat, pace maker etc.
- ☐ **Digestive system:** Ulcer, Irritable Bowel Syndrome, trouble swallowing etc.
- ☐ **Respiratory system:** Asthma, seasonal allergies, COPD etc.
- ☐ **Genitourinary system:** Severe PMS or menstrual problems**,** currently pregnant/ breast feeding**,** urinary or bowel issues. etc.
- ☐ **Musculoskeletal system / connective tissue:** Osteoporosis**,** Arthritis**,** Scoliosis, neck/spine/back problems, etc.
- ☐ **Endocrine system, nutrition / metabolic:** Diabetes, problems with: Appendix, Kidney, Liver, Thyroid, Gallbladder etc.
- ☐ **Neoplasm (Cancers):** Leukemia**,** skin Cancer etc.
- ☐ **Blood & blood Forming organs & immune system:** Hemophilia, anemia, HIV etc.
- ☐ **Congenital & Chromosomal:** Huntington's**,** Down's syndrome**,** FASD**,** Autism, SMA etc.
- ☐ **Mental Illness:** Eating disorder**,** Schizophrenia**,** Anxiety**,** Depression**,** memory loss (short or long) etc.
- ☐ **Injury, or other consequences of external causes:** Fractures or breaks, surgeries, brain injury, amputation etc.
- ☐ **Skin conditions:** Lupus**,** Psoriasis**,** Eczema or dermatitis etc.

If you have checked any of the above boxes **please provide details** (date/s, treatment, current status etc. **Attach additional pages if necessasry**_____

_____

_____

_____

_____

_____

_____

Are you taking ANY medications? (Prescription, over the counter or herbal supplements) **YES** **NO**
Please list:

_____

_____

_____

_____

Will you be bringing these medications with you on your trip? **YES** **NO**
If you answered YES above please be prepared to bring a duplicate set for the Trip Leader to carry if your trip involves a remote destination.

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MOBILITY: Are you independently ambulatory? **Yes** **No** ambulatory with an assistive device? **Yes** **No**

Please provide a list of any assistive devices or personal care devices you will using when participating (manual or power wheelchair, crutches, walker, cane, braces/orthotics, catheter, respirator, hearing aid, communication devices etc.)

_____

_____

TRANSFERRING:
Do you transfer independently? **YES** **NO** with assistance from another person or device? **YES** **NO**
Do you have pain during transfers? **YES** **NO**
Please explain:

_____

_____

_____

COMMUNICATION: Average communication abilities, uses Sign language, apraxia, aphasia (receptive/expressive), uses communication device, does not communicate etc.

_____

_____

Do you use nicotine products? **YES** **NO** if yes how much/day_____
Do you currently have a substance abuse or chemical dependency issue (drugs, alcohol, etc.)? **YES** **NO**

_____

_____

Do you have a history of chemical dependency? **YES** **NO** (If yes please describe)

_____

_____

Are you up to date on standard immunizations as outlined by the Canada Health Agency? If no please explain:

_____

_____

Please list any medical or physical concerns that have not been covered in the above answers that may affect your participation in activities. (I.e. pain, range of motion limitations etc.)

_____

_____

_____

_____

*****THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE AS OF*****

_____ _____ _____
(Day) **(Month)** **(Year)**

_____ _____
Legal Name (print clearly) **Signature**

_____ _____
Name of parent or legal guardian (If under the age of 18 or unable to sign) Signature of parent or guardian