



Dear

Thank you for your interest in the Activity Based Locomotor Exercise (ABLE) Program at Courage Center. We are excited about our new and innovative program, the first of its kind in our area. Through this program we have the opportunity to work with each client to develop a unique exercise plan utilizing a variety of specialized equipment and techniques. This intensive, activity-based exercise plan is customized to meet your needs. Results include: increased cardiovascular/aerobic fitness, muscular strength and flexibility to improve your overall quality of life.

Courage Center was chosen in 2010 to be a Community Fitness and Wellness facility as part of the Christopher and Dana Reeve Foundation's NeuroRecovery Network. We are proud to offer this combined program as a means to improve overall health and quality of life. There is scientific and clinical evidence that supports the effectiveness of the interventions to improve or maintain health and fitness for life.

We have an excellent team of highly trained staff with backgrounds in physical therapy, occupational therapy, fitness and exercise science. Our staff has the knowledge and skill to develop individualized exercise plans to help you meet your fitness expectations and goals. This highly motivated and energetic team will welcome you and answer any questions you may have about the program.

We encourage you to take advantage of this great opportunity. Please look over the enclosed forms and fact sheets to learn about the interventions our program offers. Please feel free to contact us if you have any questions or concerns.

If you are interested, please complete the Application form, Medication list and Physician referral form. Return all forms to:

ABLE Program  
3915 Golden Valley Road  
Minneapolis, MN 55422  
Phone: 763-520-0600  
Fax: 763-520-0899  
Email: [able@couragecenter.org](mailto:able@couragecenter.org)

Thank you for your time and consideration,

*Rachel Kath-Dvorak*

Rachel Kath-Dvorak, PT, Facility Supervisor  
Courage Center ABLE Program, 763-520-0600

Courage Center Golden Valley  
3915 Golden Valley Road  
Minneapolis, Minnesota 55422

p: 763.588.0811

[www.CourageCenter.org](http://www.CourageCenter.org)





## **ABLE: Activity-Based Locomotor Exercise**

### **FACT SHEET**

#### **Overview:**

In the effort to provide a continuum of care in the area of health and wellness, the ABLE Program at Courage Center will provide individuals with disabilities the opportunity to be 'fit for life'. This program is an activity-based exercise program designed specifically for individuals with physical disabilities in the community. This fully accessible facility is designed to assist clients to improve cardiovascular/aerobic fitness, muscular strength and flexibility.

#### **Opportunities:**

The ABLE Program offers:

- Professionally trained staff
- State-of-the-art equipment (TheraStride, FES Bikes, VitaGlide, WAVE ProElite, Paramount, UpperTone, and other accessible fitness equipment)
- Customized exercise programs
- Membership packages

#### **Criteria for Joining the Community Fitness and Wellness Facility:**

- Applicant must be an individual with a physical disability.
- Meet with a member of the facility staff to complete a membership application.
- Participate in a facility tour and evaluation session to receive instruction for proper use of all equipment.
- Provide a completed medical release form signed by your primary physician.

#### **Membership Packages:**

- All packages include an assessment and orientation to the facility, staff and fitness equipment
- All packages will be customized to meet individual needs
- See Payment Agreement and Packages Form for detailed information



## HOW TO PREPARE FOR YOUR **ABLE** ASSESSMENT

1. Wear comfortable shoes with socks, loose fitting pants or shorts, and a loose fitting short-sleeved shirt.
2. Only minimal physical activity is recommended before your assessment.
3. It is best to avoid alcohol, caffeine, or smoking within 3 hours of your assessment.
4. The assessment may be fatiguing, so you may want to have a friend or family member available to drive you home if this is an issue for you.

## **ABLE PROGRAM EXCLUSIONS**

Courage Center ABLE Program will not be able to accommodate certain disabilities and situations. This includes:

1. Uncontrolled diabetes
2. Heart attack within the past 6 months
3. Unstable angina (chest pain)
4. Uncontrolled seizures
5. Osteoporosis
6. Uncontrolled autonomic dysreflexia
7. Uncontrolled hypotension
8. Clients weighing more than 275 pounds may not be eligible for all interventions



# APPLICATION FORM

## ABLE: Activity Based Locomotor Exercise

Last name \_\_\_\_\_ First name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Country \_\_\_\_\_ Social Security number \_\_\_\_\_

E-mail address \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

Emergency contact \_\_\_\_\_

Emergency contact phone \_\_\_\_\_

Date of birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Gender  Male  Female

Are you receiving other services related to your medical diagnosis?  Yes  No  
List:

### PHYSICIAN INFORMATION:

#### **PRIMARY CARE:**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_

Specialty \_\_\_\_\_

#### **PHYSICAL MEDICINE & REHABILITATION:**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_

**Medical diagnosis:**

- Brain injury
- Stroke
- Multiple sclerosis
- Cerebral palsy
- Other \_\_\_\_\_

Date of onset \_\_\_\_\_

- Spinal cord injury

Date of injury \_\_\_\_\_ Cause of injury \_\_\_\_\_

Level of injury \_\_\_\_\_  Complete  Incomplete

ASIA (if known):

**Current problems limiting your independence:**

**What are your goals?**

- Strength
- Mobility
- Improved health
- Increased independence
- Home exercise program
- Other \_\_\_\_\_

Are you currently participating in other Courage Center programs?  Yes  No  
List:

**How did you hear about the program?**





## PHYSICIAN'S REFERRAL FORM

**PHYSICIAN:** If you would like to refer your patient to Courage Center's Specialist in SCI Medicine, to provide the comprehensive intake evaluation and complete this form, please check here:  Yes  No

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_

The Courage Center ABLE Program is a community fitness and wellness facility for individuals with physical disabilities. The goal is to improve overall health, personal fitness, and quality of life through appropriate but challenging interventions to improve flexibility, muscle strength, and cardiovascular/aerobic fitness. Individualized exercise programs will be created after an assessment.

Individual programs may consist of a combination of the following interventions:

Balance	Cardiopulmonary	Circuit training	FES bicycle*
Gait training	Locomotor training*	Nutrition	Trunk stability
Vertical vibration	Warm water pool	Weight management	Yoga

\* see page 3 for more explanation

Please help us ensure that your patient can safely participate in these activities by completing the following questionnaire and indicate any restrictions you deem to be appropriate.

Approved No Restrictions

Approved with Precautions \_\_\_\_\_

Bone Density Evaluation Recommended

Not Approved

Please indicate any other concerns or precautions related to this patient being able to participate in this intensive program and the interventions discussed above:

COMMENTS \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Thank you in advance for your consideration. We would be happy to assist you as needed. Please do not hesitate to contact the ABLE staff at 763-520-0600 with any questions.

The ABLE Community Fitness and Wellness Program is a collaborative effort of Courage Center and The Christopher and Dana Reeve Foundation's NeuroRecovery Network.

**NEUROLOGICAL:** Please describe all neurological diagnoses:

**CARDIOVASCULAR:** Does your patient have any risk factors that may impact his/her ability to exercise safely at high intensity?  Yes  No

MET Level:

Please describe:

**PULMONARY:** Does your patient have any pulmonary disease?  Yes  No

Please describe:

**MUSCULOSKELETAL:** Does your patient have any musculoskeletal condition that might impact his/her ability to exercise or engage in weight bearing through his/her arms and legs or participate in the use of whole body vertical vibration?  Yes  No

Please describe:

Has a bone density exam been conducted within the last 12 months?  Yes  No

Please indicate findings:

**PSYCHOLOGICAL:** Does your patient have psychological symptoms that could affect his/her participation in an intensive fitness program?  Yes  No

Please describe:

**PAIN:** Does your patient have any pain management issues that could affect his/her participation in an intensive fitness program?  Yes  No

Please describe:

**INTEGUMENTARY:** Does your patient have integumentary issues that could have an impact on his/her participation in an intensive rehabilitation program?  Yes  No

Please describe:

**MISCELLANEOUS:** Does your patient have any other medical or rehabilitation issues that were not addressed above?

## FES BICYCLE

The Functional Electrical Stimulation (FES) Bicycle utilizes low voltage electrical stimulation administered via electrode pads placed over specific muscle groups and sequenced through a microprocessor to fire the targeted muscle groups in the proper sequence to facilitate coordinated movements. The most common area is the quadriceps, hamstrings and gluteals to facilitate peddling while in a seated position. The RT 300 FES also allows stimulation of trunk (abdominals and back extensors) and, with additional equipment, the upper extremities.

**Absolute contraindications:** cardiac demand pacemakers, unhealed fractures and pregnancy.

**Relative contraindications:** denervated muscles to be stimulated, severe spasticity, limited range of motion, severe osteoporosis, dysesthetic pain syndrome, pressure sores or open wounds in areas to be stimulated, implanted hardware less than 3 months old.



## LOCOMOTOR TRAINING (LT)

Locomotor training utilizes a specialized deweighting harness system positioned over an elevated treadmill. Two therapists/technicians are positioned in special seating next to each leg and a third stands behind the harnessed person to stabilize the hips. The principle of locomotor training is to assist the stepping process by providing appropriate sensory cues to the flexor and extensor surfaces of the lower leg during locomotion. Partial weight bearing (and deweighting) allows for freedom of movement and input through the feet. Neural retraining occurs as the nervous system relearns motor patterns associated with walking. Repetitive episodes increase overall fitness.

**Precautions/Considerations:** Since partial weight bearing is involved with LT, individuals at risk for osteoporosis may require bone density evaluation and gradual weight bearing intervention prior to participating in LT. Previous unstable joints (hip, knee, ankle) or joints with underlying conditions predisposing to injury may be problematic and may require evaluation. Individuals experiencing significant orthostatic hypotension may not be appropriate candidates.



## INTERVENTIONS DESCRIPTIONS

**Locomotor Training with Over Ground Activities:** This intervention includes stretching prior to treadmill session, application of the specialized support harness, 45 minutes on the treadmill with the assistance of a minimum of four Fitness Specialists followed by 30 minutes of over ground activities off of the treadmill. Treadmill activities will include work on all components of standing and walking based on the client's needs and goals. Over ground activities are completed with assistance from a Fitness Specialist and will vary based on specific needs identified during the assessment and locomotor training. It will include a variety of activities in sitting, standing and walking. This approach is essential to maximize benefits for the client. Studies indicate that effects of locomotor training are optimized with use of both the Body Weight Supported Treadmill and over ground training. Locomotor training will be scheduled for 1 ½ hours. This intervention requires written approval from your physician and may only be appropriate for specific diagnoses. An assessment is required and will be completed prior to starting any locomotor activity.

**LT 3:** Locomotor training 3 times a week for four weeks - \$2100

**LT 2:** Locomotor training 2 times a week for four weeks - \$1400

*Single Sessions may only be scheduled as available, one week in advance.*

*Cost: \$175.00/single session*

**Functional Electrical Stimulation (FES):** Use of the FES bike has been shown to improve cardiovascular capacity, improve bone health, decrease occurrence of complications such as skin breakdown, improve glucose tolerance, increase muscle cross sectional area, improve heart rate, stroke volume and cardiac output, decrease spasticity, increase local blood circulation, and maintain or increase range of motion. This intervention requires the approval of your physician and may only be appropriate for specific diagnoses. This intervention will require an assessment that will be completed prior to start. It may include 1 or more of the following options:

- Lower Extremity: Electrodes are placed on the muscles of the legs
- Trunk: Electrodes are placed on the trunk muscles in conjunction with some select arm or leg muscles. This will be determined at time of the assessment.
- Upper Extremity: Electrodes are placed on specific muscles of the arms

*Single Session Cost: \$120.00*

- RT600: Body weight supported elliptical ergometer

*Single Session Cost: \$150.00*

**Guided Exercise:** This intervention includes individual instruction and assistance from a Fitness Specialist. Sessions may include strengthening and/or cardiovascular exercise. A variety of specialized exercise equipment can be utilized during these sessions. The equipment and exercises will be customized to meet each client's individual needs. The equipment utilized may include but is not limited to: WAVE ProElite, UpperTone, Paramount, VitaGlide, Giger MD, Total Gym, Bioness and Stiwel e-stim.

*Single Session Cost: \$75.00*

**Basic Memberships:** Independent membership to the Fitness Center:

- \$45/ month (unlimited use)
- \$110 for a 3 month pass (unlimited use)

## DISCOUNTS

To maximize the benefits for our clients the ABLE program recommends high intensity activity based exercise 3-4 hours a day, 3 days a week for 12 weeks. This recommendation is based on the most current scientific research regarding the level of intensity needed to achieve results. A 10% discount will be applied when purchasing 2 or more interventions 3 days per week with advance payment for a 12-week commitment.

3915 Golden Valley Road  
Minneapolis, MN 55422  
763.588.0811

12400 Portland Ave S  
Burnsville, MN 55337  
952.898.5700

1460 Curve Crest Blvd  
Stillwater, MN 55082  
651.439.8283

146 North Lake Street  
Forest Lake, MN 55025  
651.464.5235

**Last name:** \_\_\_\_\_ **First name:** \_\_\_\_\_ **MI:** \_\_\_ **Date:** \_\_\_\_\_

**Birthdate:** \_\_\_\_\_ **Medical diagnosis:** \_\_\_\_\_

**How well do you speak English?**  Fluently  English understood  Interpreter needed  
If not English, what is your primary language:

**Do you drive?**  Yes  No If no, did you drive previously?  Yes  No

**Are you**  right-handed  left-handed

**Where do you live?**

- Private home  Board and care/assisted living/group home  
 Private apartment  Long-term care facility (nursing home)  
 Other:

**After discharge from therapies, do you plan to remain in your current living situation?**

Yes  No If no, is there anything you would like your therapist to address with you prior to discharge?

**With whom do you live?**

- Alone  Children (no other adults)  Personal care attendant  
 Spouse only  Other adult(s)  Other:  
 Spouse and children  Group Setting

**Do you provide care for:**  A dependent child  A dependent adult  A pet

**Are there any obstacles that prevent you from getting in or out of your home or moving around your home freely?**  Yes  No If yes, please specify:

**Work status:**  Working  Retired  Unemployed  Disabled  Stay-at-home parent  
If working: Occupation \_\_\_\_\_ Any restrictions? \_\_\_\_\_

**Comfort in water:** *(For water therapy only)* Are you:  An independent swimmer  
 Non-swimmer, but comfortable in chest deep water  Afraid of/not comfortable in water

**Are you interested in getting more information about:**  Driving program  
 Recreational services  Social services  Support groups  Vocational services

If female, are you:  Pregnant  Breast feeding

**History of current problems:** What is/are the primary reason(s) that brought you to Courage Center?

If related to a recent problem, when did the problem(s) begin? Month: \_\_\_\_\_ Year: \_\_\_\_\_

Did the problem(s) begin:  Gradually  After an accident  
 After an illness  After surgery

Are you currently experiencing pain?  Yes  No

What makes the problem(s) better?  Medications  Changing position  Heat/cold  Rest  
 Other:

**Have you been hospitalized in the past year?**  Yes  No If yes, date:

Reason:

**Have you ever had surgery?**  Yes  No If yes, please describe and include dates:

\_\_\_\_\_ month: \_\_\_\_\_ year: \_\_\_\_\_  
 \_\_\_\_\_ month: \_\_\_\_\_ year: \_\_\_\_\_  
 \_\_\_\_\_ month: \_\_\_\_\_ year: \_\_\_\_\_

**Medications:** Please list any prescription medication and dosage. Attach list, if needed:

\_\_\_\_\_  
 \_\_\_\_\_

**Do you take any non-prescription medications?** *(Check all that apply):*

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Advil/Ibuprofen | <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Herbal supplements |
| <input type="checkbox"/> Aleve/Naproxyn  | <input type="checkbox"/> Aspirin        | <input type="checkbox"/> Tylenol            |
| <input type="checkbox"/> Antacids        | <input type="checkbox"/> Decongestants  | <input type="checkbox"/> Other:             |

**Within the past year, have you had any of the following symptoms?** *(Check all that apply):*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Chest pain             | <input type="checkbox"/> Loss of balance                | <input type="checkbox"/> Shortness of breath       |
| <input type="checkbox"/> Coordination problems  | <input type="checkbox"/> Loss of bowel/bladder control  | <input type="checkbox"/> Swallowing difficulty     |
| <input type="checkbox"/> Difficulty sleeping    | <input type="checkbox"/> Memory problems                | <input type="checkbox"/> Weakness of arms or legs  |
| <input type="checkbox"/> Difficulty walking     | <input type="checkbox"/> Pain at night                  | <input type="checkbox"/> Weakness of face or voice |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Reduced speech intelligibility | <input type="checkbox"/> Weight loss/gain          |
| <input type="checkbox"/> Headaches              |   | <input type="checkbox"/> Word finding problems     |
| <input type="checkbox"/> Joint pain or swelling |   | <input type="checkbox"/> Other:                    |

**Within the past year, have you had any of the following medical tests?**

*(Check all that apply):*

- |                                       |  |   |
|---------------------------------------|--|---|
| <input type="checkbox"/> Angiogram    | <input type="checkbox"/> EKG (electrocardiogram)       | <input type="checkbox"/> Spinal tap                       |
| <input type="checkbox"/> Arthroscopy  | <input type="checkbox"/> EMG (electromyogram)          | <input type="checkbox"/> Stress test (treadmill)          |
| <input type="checkbox"/> Bone scan    | <input type="checkbox"/> Myelogram                     | <input type="checkbox"/> Swallow study (videofluoroscopy) |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Neuropsychological evaluation | <input type="checkbox"/> X-rays                           |
| <input type="checkbox"/> CT scan      |  |   |

**Have you previously or are you now seeing anyone else for the problem(s)?**

*(Check all that apply):*

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Acupuncturist           | <input type="checkbox"/> Neurologist                 | <input type="checkbox"/> Psychiatrist              |
| <input type="checkbox"/> Cardiologist            | <input type="checkbox"/> Neuropsychologist           | <input type="checkbox"/> Physical therapist        |
| <input type="checkbox"/> Chiropractor            | <input type="checkbox"/> Obstetrician/gynecologist   | <input type="checkbox"/> Podiatrist                |
| <input type="checkbox"/> Dentist                 | <input type="checkbox"/> Occupational therapist      | <input type="checkbox"/> Primary care physician    |
| <input type="checkbox"/> Internist               | <input type="checkbox"/> Ophthalmologist/optometrist | <input type="checkbox"/> Rheumatologist            |
| <input type="checkbox"/> Massage therapist       | <input type="checkbox"/> Orthopedist                 | <input type="checkbox"/> Speech/language therapist |
| <input type="checkbox"/> Mental health counselor | <input type="checkbox"/> Osteopath                   | <input type="checkbox"/> Other:                    |

If checked above, please provide:

Name of provider:

Date of last visit:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Do you use?** *(check all that apply):*

- |  |   |                                 |
|--|---|---------------------------------|
| <input type="checkbox"/> Glasses                                 | <input type="checkbox"/> Manual wheelchair    | <input type="checkbox"/> Cane   |
| <input type="checkbox"/> Hearing aids                            | <input type="checkbox"/> Motorized wheelchair | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Orthotics/Splints/Brace Type:           | Vendor:                                       |                                 |
| <input type="checkbox"/> Augmentative communication system Type: |   |                                 |
| <input type="checkbox"/> Other:                                  |   |                                 |

**Are you having any difficulty in these functional areas?** *(Check all that apply):*

Household:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Carrying                       | <input type="checkbox"/> Managing money/budget | <input type="checkbox"/> Sweep/mop/rake |
| <input type="checkbox"/> Cooking                        | <input type="checkbox"/> Pushing/pulling       | <input type="checkbox"/> Vacuuming      |
| <input type="checkbox"/> Laundry                        | <input type="checkbox"/> Reaching overhead     | <input type="checkbox"/> Other:         |
| <input type="checkbox"/> Lifting more than _____ pounds | <input type="checkbox"/> Shopping              |   |

Psychosocial:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Anger management    | <input type="checkbox"/> Depression             | <input type="checkbox"/> Relationships |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Inappropriate behavior | <input type="checkbox"/> Other:        |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Pain management        |  |

Personal:

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Bathing      | <input type="checkbox"/> Eating                       | <input type="checkbox"/> Sexual relations |
| <input type="checkbox"/> Computer use | <input type="checkbox"/> Grooming                     | <input type="checkbox"/> Sleeping         |
| <input type="checkbox"/> Dressing     | <input type="checkbox"/> Handcrafts/leisure interests | <input type="checkbox"/> Sports           |
| <input type="checkbox"/> Driving      | <input type="checkbox"/> Managing medications         | <input type="checkbox"/> Other:           |

Communication/Cognition:

- |                                      |  |  |
|--------------------------------------|--|--|
| <input type="checkbox"/> Attention   | <input type="checkbox"/> Memory          | <input type="checkbox"/> Speaking      |
| <input type="checkbox"/> Hearing     | <input type="checkbox"/> Orientation     | <input type="checkbox"/> Swallowing    |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Problem solving | <input type="checkbox"/> Understanding |
| <input type="checkbox"/> Initiation  | <input type="checkbox"/> Reading         | <input type="checkbox"/> Writing       |
| <input type="checkbox"/> Other:      |  |  |

Mobility:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Bending down   | <input type="checkbox"/> Getting in/out of car | <input type="checkbox"/> Getting up from floor        |
| <input type="checkbox"/> Stairs   | <input type="checkbox"/> Getting in/out of bed | <input type="checkbox"/> Getting up from chair/toilet |
| <input type="checkbox"/> Sitting more than _____ minutes                        |  |   |
| <input type="checkbox"/> Standing more than _____ minutes                       |  |   |
| <input type="checkbox"/> Walking more than _____ minutes or a distance of _____ |  |   |
| <input type="checkbox"/> Other:   |  |   |

**Do you have any other medical considerations/directives that you would like us to be aware of** *(such as DNR, DNI)?*

**Is there any additional information you want to share?** *(For example, cultural or spiritual beliefs that affect care.)*

**Form completed by:** \_\_\_\_\_ **Relationship to client:** \_\_\_\_\_