Kinesiology Intake Form

SECTION A – GENERAL INFO

NAME _____ Pronoun _____

STREET ADDRESS _____

CITY _____ PROVINCE _____ POSTAL CODE _____

HOME/CELL# _____ WORK# _____

DATE OF BIRTH: M_____ D_____ Y_____

OCCUPATION _____

EMPLOYER _____

EMERGENCY CONTACT: _____PHONE # _____

FAMILY DR. _____PHONE # _____

REFERRING DR. _____PHONE # _____

SECTION B – HEALTH HISTORY

Are you presently receiving, or have you ever received any of the following treatments for your current condition?

- Chiropractic
- Reflexology
- Massage
- Acupuncture
- Occupational Therapy
- Physiotherapy
- Naturopathic
- Podiatry/Chiropody
- Other _____

Please indicate the reason for your interest in a Kinesiology program

_____

_____

Primary barriers to participation in kinesiology program:

_____

_____

Have you seen a kinesiologist previously?___No _____Yes

If you answered "yes" did you find it to be helpful? _____

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Description of Job (if applicable), including hours, nature of job, etc.:_____

_____

Description of your daily activities (includes family, social, physical aspects, ect...):

_____

_____

_____

Please check any of the following conditions that you have:

- Thyroid Condition
- Osteoporosis
- Dizziness/Fainting
- Smoking History
- Low/High Blood Pressure
- Raynauds
- Heart Condition/Disease
- Recent Falls/Blackouts
- Unexplained Weight Loss
- Broken Bones/Fracture
- Shortness of Breath
- Asthma
- Bronchitis
- Recent Infection (chest, urinary tract, etc.)
- Chronic Obstructive Pulmonary Disease (COPD)
- Emphysema
- Lung Cancer
- Cystic fibrosis
- Pneumonia
- Diabetes
- Sleeping Problems
- Chest Pain
- Heart Palpitations
- Cough
- Metal Implants
- Pacemaker
- Vision Difficulties
- History of Cancer
- Swallowing Difficulties
- Any Allergies
- Allergies to tape/latex
- Slurred Speech
- Brain injury
- Memory Problems
- Headaches
  Epilepsy/Seizures
- Depression
- Dizziness/Blackouts
- Balance Problems
- Kidney
- Loss of Coordination
- Problems
- Arthritis
- Groin Numbness/Tingling
- Respiratory Condition
- Bowel/ Bladder Difficulties
- Hearing Impairment
- Hernia
- Cancer
- Pregnancy
- Blood Diseases
- Blood clots or clotting
- disorder
- Easily bruising (use of blood thinning medication: warfarin, Coumadin, etc)
- Other _____

Do you presently, or have you ever, suffered from any of the following infections? (Check all the apply)

- None
- HIV/AIDS
- Hepatitis
- Tuberculosis
- MRSA/CPE
- Other _____

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Medications (please list all medications currently prescribed and their purpose):

_____

_____

_____

Supplements (please list all supplements currently taking and their purpose):

_____

_____

_____

How often do you experience pain? _____

For recurring issues, what is your lowest level of pain on a daily basis? (zero = no pain)

0 1 2 3 4 5 6 7 8 9 10

For recurring issues, what is your highest level of pain on a daily basis?

0 1 2 3 4 5 6 7 8 9 10

Description of pain (where it is; how often you feel it; what it feels like; does it go away?):

_____

_____

Female Participants

Are you pregnant, or planning to become pregnant in the next 6 months?

Do you suffer from:

____Menstrual period problems

____Incontinence

____Prolapse

____Urine loss when you cough, sneeze, or laugh

If yes, have you received treatment in the past?

Comments:

Current Physical Activity

In a given day, how many minutes are you engaged in mild-to-moderate physical activity?

_____

How many days per week do you participate in mild-to-moderate intensity activity?

_____

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Preferred forms of physical activity (check all that apply)

- Walking
- Nordic Walking
- Running
- Cycling
- Resistance Training
- Swimming
- Group Fitness
- Equestrian
- Hiking
- Gardening
- Dancing
- Gymnastics
- Martial Arts
- Crossfit
- Other
- 1.
- 2.
- 3.
- 4.

Is there anything else you would like to add:

_____

_____

_____

_____

_____

_____

_____

Signature of Kinesiologist: _____

Date _____

5.

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