Move Past Pain to Performance
Client Intake Form

Name: ____

Address: ____

City/State/Zip: ____ Birthday: ___________________

Phone: ____ Email: ____

Occupation: ____

Emergency Contact: _____________________________________ Phone: ___________________________

General Information:

What is your main reason for coming to MP3? ____

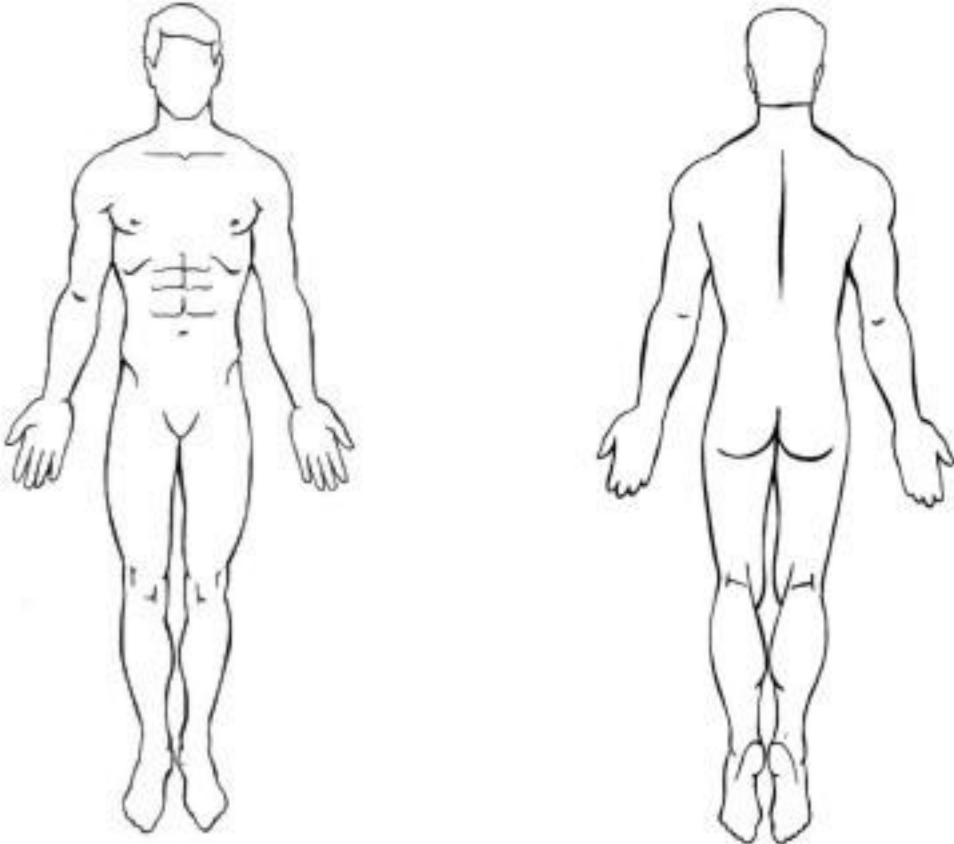
What specific fitness/wellness goals would you like to achieve? ____

____

____

How and when did the symptoms begin? ____

Please mark symptom areas on the figures below:



How long have you had these symptoms? ____________________________

Are you currently, or have you ever been, under medical supervision for this problem? Was there a diagnosis?

____

____

When was your last physical exam? ____

Have you had any tests for this problem; such as x-rays, MRI or CT scans? _________________________________

____

What time of day is the pain worse? ___________________________________. Please check all that apply:

□ Dull □ Ache □ Burning □ Sharp □ Periodic □ Constant □ Sore □ Stiff □ Numb □ Tingling

What makes it better or worse? ____

On a scale of 0 to 10 (10 as worst), what is your discomfort level right now? ______________

Any areas of tingling or numbness? ____

Any limited Range of Motion? ____

Do you have trouble sleeping? ______ If yes, what position do you sleep in? __________________________________

What are your daily activities? ____

____

Physical Factors:

What exercise/fitness are you doing? ____

____

Have you ever had chiropractic treatment? If yes, how long, and with whom? ________________________________

____

Have you experienced any kind of bodywork before (i.e. massage, acupuncture, etc.)? If yes, what type? __________

____

Do you wear orthotics? __________ If yes, for how long? ____

What percentage of your day is spent sitting? ___________ Standing? ___________ Driving? _____________

Are your symptoms worse at the end of the workday? ____

Does your work station give you support and encourage good posture? ______________________________________

How would you rate your own posture? ____

Medical History:

Please list any and all diagnosis, dental work, injuries, surgeries, accidents, falls, head injuries, burns, broken bones, sprains, tears, etc.

Age 0-10 ____

____

Age 11-20 ____

____

Age 21-30 ____

____

Age 31-40 ____

____

Age 41-50 ____

____

Age 51-65 ____

____

Age 66+____

____

List current supplements, and medications____

____

____

____

____

____

Do you wear glasses, contact lenses? (if yes, do you know your prescription?) ___________________

____

Have you had any significant changes in vision, or corrective eye surgery? ______________________

____

Any surgeries, or traumatic experiences to your teeth, mouth, or jaw? __________________________

____

Do you ever get, or have you ever had dizziness or vertigo? ________________________________

Please check all that apply:

____ Cancer	____ Hi/Low Blood Pressure	____ Epilepsy
____ Digestion Problems	____ Elimination Problems	____ Ulcers
____ Cancer: Type _____	____ Respiratory Problems	____ Cold Hands/Feet
____ Migraines/Headaches	____ Sinus Problems	____ Heart Problems
____ Back Problems	____ Neck Problems	____ Bruise Easily
____ Sciatica	____ Arthritis/Bursitis	____ Allergies
____ Stroke	____ Immune Disorder	____ Fibromyalgia
____ Scoliosis	____ TMJ	____ Carpal Tunnel
____ Osteoporosis	____ Tendonitis	____ Asthma
____ Diabetes	____ Now Pregnant	____ Immovable Joints

MP3 Informed Consent

The above information is accurate and true to the best of my knowledge. If there are any changes in my current level of health, I will inform my MP3 trainer/therapist. I understand that MP3 does not diagnose or treat illness or disease, and does not prescribe medications.

I, the undersigned, am aware that participation in any exercise program may be injurious to my health, and I am voluntarily participating in physical activity with Move Past Pain to Performance (MP3), and any employees and contractors hired by MP3.

Having such knowledge, I hereby release MP3, and all employees, officers, and contractors hired by MP3 from liability for accidental injury or illness I may incur as a result of participation in the said physical activity. I hereby assume all risks connected therewith, and consent to participate in said program.

I agree to disclose any physical limitation, disabilities, ailments, or impairments, which may affect my ability to participate in said fitness program.

Signature ____ Date____________________

Cancelation Policy - Strict:

Please provide at least 7 days advanced notice if your session needs to be canceled or rescheduled. If 7-day notice is not provided, you will be charged the standard session fee. For sickness, unavoidable circumstances, emergencies, and loss of a loved one, MP3 accepts “emergency cancellation” at any time, but only one “emergency cancellation” will be accepted per 6-month period.