

Move Past Pain to Performance

Client Intake Form

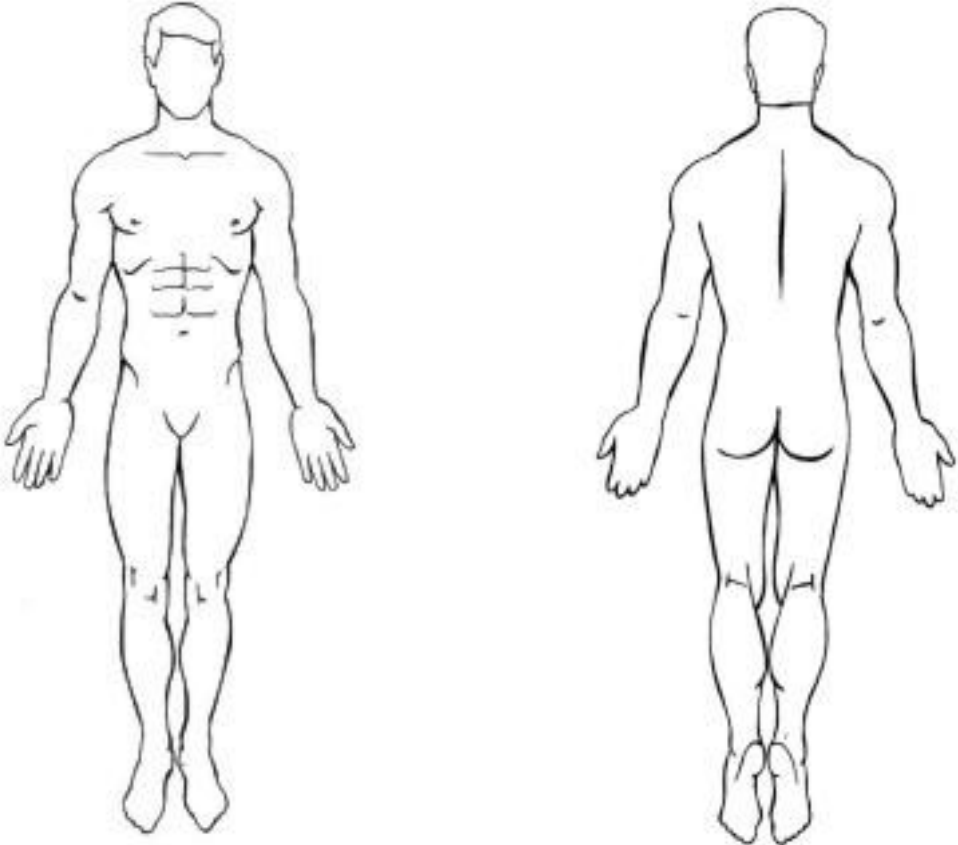
Name: _____
Address: _____
City/State/Zip: _____ Birthday: _____
Phone: _____ Email: _____
Occupation: _____
Emergency Contact: _____ Phone: _____

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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hi/Low Blood Pressure | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Elimination Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer: Type _____ | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Cold Hands/Feet |
| <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Arthritis/Bursitis | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Immune Disorder | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> TMJ | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Now Pregnant | <input type="checkbox"/> 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 _____

Cancellation Policy:

Please provide at least 24-hour notice if your session needs to be canceled or rescheduled. If 24-hour notice is not provided, the session will be forfeited, and you will be charged for the full amount of the session time. Obvious and unavoidable emergencies will be taken into consideration.