Date of Initial Health History: _____
Update 1: _____
Update 2: _____
Update 3: _____

HEALTH INTAKE FORM

Date:_____

PLEASE TELL US ABOUT YOURSELF:

SEX: MALE / FEMALE

Name_____Address_____City/Province _____

Postal Code_____Home Tel:_____Cell:_____Bus. Tel:_____

Occupation:_____Company Name:_____Date of Birth (DD/MM/YYYY) _____

E-mail_____**Referred By?** (family/friend/physician):_____

In case of emergency, whom may we contact? Name_____Tel: _____

Medical Doctor:

Name_____Tel:_____Date of Last Physical: _____

REASONS FOR CONSULTING In Motion:_____

Are you here as the result of a motor vehicle accident or workplace accident?_____
If Yes, please provide claim number and details:_____

PLEASE BRIEFLY DESCRIBE YOUR MEDICAL HISTORY:_____

_____

DO YOU CURRENTLY TAKE ANY MEDICATIONS, VITAMINS or SUPPLEMENTS_____

Name of Extended Health Insurance Provider (if applicable):_____

CONFIDENTIALITY:

I authorize the sharing of health, fitness and personal infomation between In Motion employees and contract staff for the benefit of improved continuity of care_____(initial).

I authorize In Motion employees and/or contract staff to contact me via the phone number(s) or email address I have provided for the purpose of confirming appointments, and/or for other reasons deemed necessary_____(initial).

I authorize the leaving of voice messages at the contact information provided_____(initial).

BILLING:

In Motion bills its clients directly through service providers and bills are due upon receipt of service. In Motion staff and contract employees work on a scheduled appointment basis. In order for us to effectively use our time, we ask that clients give In Motion a 24-hour notice when canceling an appointment. This means a cancellation should be made at least 24 hours before the scheduled appointment. Appointments cancelled inside of 24 hours of the scheduled time may be billed a set rate. All cancelled appointments outside the 24-hour time frame can be rescheduled at the earliest convenience.

I have read and understand the above billing agreement, and accept these policies as they relate to health and fitness activities with In Motion.

_____ _____

Client Signature Date

In Motion: Health-Wellness-Fitness
6-1150 Pontiac Drive
Sarnia, ON N7S 3A7

LIFESTYLE QUESTIONNAIRE

Name: _____ Date: _____

Alcohol/Caffeine/Tobacco Consumption

How often do you consume alcohol? ___
On the days you drink, on the average how many drinks do you have? ___
How often each day do you consume caffeine in your diet including coffee, tea, cola or chocolate? _____

Indicate which of the following best represents your current status. Check all that apply. ___ 1) Have never smoked____2) Quit smoking less than 5 years ago ___3) Quit smoking more than 5 years ago__4) Smoke pipe or cigar___ 5) Smoke less than 1 pack of cigarettes per day ___ 6) Smoke more than 1 pack of cigarettes per day Do you use smokeless tobacco?

Exercise Program

On the average, how many days per week do you exercise? ___

What do you do for exercise? _____

Nutrition Habits

On the average how many meals do you consume per day? ___

On the average, indicate the amount of grain products you normally consume per day.
NOTE: A serving is 1 sl. bread, 1/3 cup beans / peas, 1/3 cup oatmeal, rice or other grain products. _____

On the average, how many servings of vegetables do you consume per day? Note: A serving is approximately 1 cup of raw or 1/2 cup of cooked. _____

On the average, how many servings of fruit do you consume per day? ___ pieces of fruit.

On the average, how many servings of dairy products do you consume per day? Note: A serving is approximately 1 cup of milk or 1 oz. of cheese. Indicate the type of dairy products you consume. _____

Indicate the type and servings of meat you normally consume per day. _____

Indicate the type and number of servings of fat, dressings and spreads you consume each day. _____

On the average, how many glasses of water do you consume per day? Note: A serving is one 8-oz. glass of water only; do not include coffee, soda or other beverages. ____

On the average how many times per day do you eat convenience foods or forms of fast food? __

Stress

Please rate your stress level: Mild / Moderate / Severe
What do you do for stress relief? _____
Do you think you have good coping strategies? ___

Sleep

How many hours do you sleep on an average night? ___
When you wake to you feel well rested? ___

Are there any other concerns you would like addressed?

PATIENT MEDICAL HISTORY FORM

Name:_____ Date: _____

Please check the appropriate box for any of the following symptoms which you now have or have previously experienced.

Neurological

- ☐ chills
- ☐ epilepsy
- ☐ dizziness
- ☐ fainting
- ☐ fevers
- ☐ headaches
- ☐ loss of sleep
- ☐ nervousness
- ☐ depression
- ☐ neuralgia
- ☐ numbness
- ☐ sweats
- ☐ loss of weight
- ☐ tremors

Muscle & Joint

- ☐ arthritis
- ☐ bursitis
- ☐ swollen joints
- ☐ hernia
- ☐ low back pain
- ☐ neck pain

Respiratory

- ☐ chest pain
- ☐ chronic cough
- ☐ difficulty breathing
- ☐ spitting blood
- ☐ throat phlegm
- ☐ wheezing

Eyes, Ears, Nose & Throat

- ☐ colds
- ☐ crossed eyes
- ☐ deafness
- ☐ dental decay
- ☐ asthma
- ☐ ear aches
- ☐ ear discharges
- ☐ ear noises
- ☐ sinus infection
- ☐ enlarged glands
- ☐ enlarged thyroid
- ☐ sore throat
- ☐ tonsillitis
- ☐ eye pain
- ☐ failing vision
- ☐ gum trouble
- ☐ hay fever
- ☐ hoarseness
- ☐ nasal obstruction
- ☐ nose bleeds

Cardio-Vascular

- ☐ rapid heart beats
- ☐ slow heart beats
- ☐ swelling of ankles
- ☐ hardening of arteries
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chest pain
- ☐ poor circulation

Gastro Intestinal

- ☐ excessive hunger
- ☐ burping or gas
- ☐ liver trouble
- ☐ colitis
- ☐ colon trouble
- ☐ constipation
- ☐ diarrhea
- ☐ difficult digestion
- ☐ abdominal distension
- ☐ stomach pain
- ☐ gall bladder trouble
- ☐ hemorrhoids
- ☐ intestinal worms
- ☐ jaundice
- ☐ poor appetite
- ☐ nausea
- ☐ vomiting
- ☐ vomiting blood

Skin

- ☐ boils
- ☐ bruise easily
- ☐ dryness
- ☐ hives or allergies
- ☐ itching
- ☐ rashes
- ☐ varicose veins

Genito-Urinary

- ☐ bed wetting
- ☐ blood in urine
- ☐ frequent urination
- ☐ loss of control of urination
- ☐ painful urination
- ☐ kidney infection
- ☐ prostate trouble
- ☐ abnormal urine smell

Pain or Numbness In:

- ☐ shoulders
- ☐ arms
- ☐ hands
- ☐ hips
- ☐ legs
- ☐ knees
- ☐ ankles
- ☐ feet
- ☐ tail bone

For Women Only

- ☐ cramps
- ☐ heavy flow
- ☐ light flow
- ☐ irregular cycle
- ☐ painful cycle
- ☐ discharge
- ☐ sore breasts
- ☐ menopausal
- ☐ pregnant

Due Date: _____

Miscellaneous

- ☐ fractures
- ☐ car accident
- ☐ hospitalized
- ☐ current smoker
- ☐ past smoker
- ☐ diagnosed with cancer
- ☐ HIV positive
- ☐ hepatitis positive

Did We Miss Anything?

In Motion: Health-Wellness-Fitness
6-1150 Pontiac Drive
Sarnia ON, N7S 3A7

COMPLAINT HISTORY FORM

Name:_____ Date: _____

What is your primary reason for seeking care today?

Please indicate the area(s) of pain or unusual feeling. Mark the area(s) on the diagrams where you feel the following sensations using the appropriate symbols. Also indicate any areas of radiation.

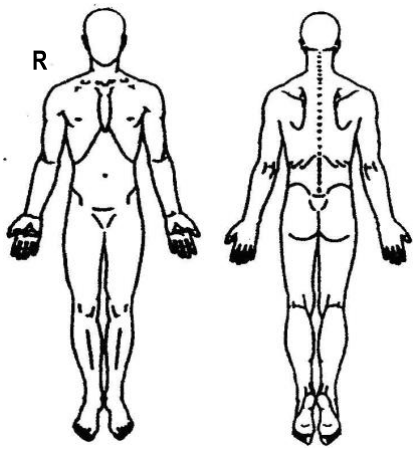
Numbness //////////////////////

Sharp/Stabbing 0000000000

Burning XXXXXXXXXXXXXX

Aching **********

Stiffness >>>>>>>>>>>>>



If you are experiencing symptoms, how long and how often have they been bothering you?

Do you know the cause of the latest episode? Have you had this problem in the past?

On a scale of 0 to 10, 10 being the worst pain imaginable, please rate your current pain level: __ / 10

What provides you with relief? What aggravates your condition?

List, with date, any surgeries, conditions (E.g. fibromyalgia, diabetes, stroke, osteoporosis, etc.) and/or injuries (E.g. falls, car accidents, etc.) you have had:

Do you have any internal pins, wires, artificial joints, or special equipment? What? Where?

Do you have a family history of cardiovascular disease, respiratory disorders, arthritis, cancer, etc.?

Have you been to a chiropractor/physiotherapist/massage therapist before? Please list any concerns or expectations that you have:

Patient Signature:
_____
Practitioner Signature:
_____

In Motion: Health-Wellness-Fitness
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