# Kinesiology Intake Form


**General Information:**

Name: _____ Birthdate: _____ Date: _____

Address: _____

City: _____Province: _____ Postal Code: _____

Phone (Home): _____Phone (Mobile): _____

Email: _____

Emergency Contact: _____ Relation: _____ Phone: _____

**What is the reason for seeking care?** _____
_____
_____

**Your Lifestyle:**

What do you do for FUN? (Hobbies/Recreation) _____
_____
_____

How many hours per day do you spend looking at a SCREEN/MONITOR?

- 0-2 hours
- 2-5 hours
- 5-8 hours
- 8+ hours

Please rate your level of PHYSICAL ACTIVITY

- None
- Mild
- Moderate
- High
- Extreme

Please rate your level of STRESS

- None
- Mild
- Moderate
- High
- Extreme

Please rate your level of NUTRITION

- Poor (I eat allot of processed foods)
- Could Improve (I typically don't eat well/ rarely prepare my own food)
- Good (I typically eat well/I prepare most of my meals)
- Excellent (I have a healthy diet/take supplements to optimize my nutrition)

Please rate your level of HYDRATION

- Poor (rarely or never drink water)
- Could improve (could drink more water)
- Good (I drink enough water)
- Extreme (I only drink water)

**Pain Levels & Information**

**Please describe the following:**

**MOI** (Mechanism of Injury)- How did the complaint begin? _____
_____
_____

**Chief Complaint**- Primary area of complaint? _____
_____
_____

**Onset Complaint**- _____
_____
_____

How frequent are your symptoms?

- Constant
- Frequent
- Intermittent
- Occasional
- Rare

Have you experienced the same (or similar) symptoms in the past? If yes, briefly describe how often these symptoms return and how long they typically last. _____
_____
_____

Quality of Pain- Please mark all that apply

- Stiff/ Tight
- Achy
- Dull
- Deep
- Sharp
- Burning
- Throbbing
- Shooting
- Other _____

Aggravating Symptoms- Does anything worsens your symptoms? _____
_____
_____

Do you have a previous history of TRAUMA/ INJURY to (or around) your area of complaint? _____
_____
_____

Please list any SURGERIES you have had preformed (including dental surgeries) _____
_____
_____

Have you had any IMAGING taken of your area of complaint? If yes? When were they taken?

- X-Ray _____
- CT Scan _____
- MRI _____
- Ultrasound_____
- Other_____

Is there anything else you want your kinesiologist to know? _____
_____

# Kinesiology Confidentiality Agreement and Informed Consent to Treatment

Kinesiology may involve the use of a variety of physical fitness evaluations and treatment techniques along with various procedures and modalities used to assist in improving your health and functional ability. As with all forms of medical treatment, there are benefits and risks involved with this type of treatment. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to any given component or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is a risk that treatment may cause pain or injury or may aggravate previously existing conditions. You will be informed what type of treatment is being planned based on your history, diagnosis, symptoms and assessment findings. You may also request additional detail regarding what the potential risks and benefits of a specific treatment might be if the initial explanation is unclear to you at any time. You have the right to decline any portion of your treatment at any time before or during your treatment sessions. Therapeutic exercises are an integral part of most treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding any part of your treatment, including any exercise and the possible risks or side effects that may be associated, it is important you advise the kinesiologist of your concerns at the earliest opportunity.

- I understand that I must inform the Kinesiologist immediately of any disease process that I may be suffering from, if I am on any medication or over the counter drugs, if I am pregnant, suspect I may be pregnant or am breast-feeding.
- I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that the practitioners at this clinic are legally obligated to supersede confidentiality if they become aware of current child abuse or neglect, threats to harm or kill another individual and serious threat of suicide involved with my case. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

***I understand that 24 hours notice is required for appointment cancellation; otherwise I will be responsible for the cancellation fee.***

- I understand that the results are not guaranteed. I do not expect that the Kinesiologist will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to therapeutic procedures mentioned above.

☐ I intend this consent form to cover the entire course of treatment with this Kinesiologist. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Acacia Health Clinic
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www.acaciahealth.ca

☐ **I further acknowledge** that following being assessed, the kinesiologist has explained to me what type of treatment they are recommending based on my medical history, diagnosis, symptoms and assessment findings. The kinesiologist has also explained to me what the potential risks and benefits of the treatment recommended might be and answered any questions I have. The kinesiologist has indicated what the risks of having and not having treatment are and what alternate treatments may be available to me that are known by the kinesiologist. I understand that it is my responsibility to follow up with the kinesiologist or my physician if I have any concerns over the recommended treatment and I hereby acknowledge that I accept any and all inherent physical risks of injury and agree to proceed with treatment, and that I have been provided details of the treatment costs and that I am responsible for payment of those costs.

**Patient/Guardian Name: (Please Print)** _____

**Signature of Patient (or Guardian):** _____

**Date**: _____

*Optional Consent (please **initial** box*)

• To provide me with truly integrated medical care I hereby give my consent to share my file and/or my medical history and current treatment plan options with any other practitioner that I am currently seeing (or may be referred to see in the future) at Acacia Integrative Health Clinic for the sole purpose of improving my current health condition and/or to discuss current and/or future treatment options.

**Kinesiologist Signature**: _____

**Date: _____**

acacia health
health, through science & nature

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