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Health History

The information requested below will assist in providing you safe and effective therapy and training. Doing this before your appointment means less time doing paperwork and more treatment/training time. Please note that all information provided below will be kept confidential. Your written permission is required to release any information.

Date:_____ Name:_____

Date of Birth:_____ Age:_____ Height:_____ Weight:_____

Address:_____ City:_____ Postal Code:_____

Phone:_____ E-mail:_____

Occupation:_____ Emergency Contact:_____ Phone:_____

Primary Care Physician:_____ Phone:_____

Referred by: _____ Have you received Personal Training Before? Yes__ No__

Have you received Massage Therapy Before? Yes _ No _

Please answer the following questions

Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?	Y	N
Do you feel pain in your chest when you do physical activity?	Y	N
In the past month, have you had chest pain when you were not doing any physical activity?	Y	N
Do you lose your balance because of dizziness or do you ever lose consciousness?	Y	N
Do you have a bone or a joint problem (for example back, knee, hip) that could be made worse by a change in your physical activity?	Y	N
Is your doctor currently prescribing drugs (for example water pills) for your blood pressure or heart condition?	Y	N
Are you currently seeking treatment from a health care practitioner If so, what type of health care practitioner and for what condition?	Y	N

Current medication & condition it treats: _____

Surgeries - Date/Nature:_____

Injury - Date/Nature:_____

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Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- ▢ High blood pressure
- ▢ Low blood pressure
- ▢ Chronic congestive heart failure
- ▢ Heart Attack
- ▢ Angina
- ▢ Phlebitis/Varicose veins
- ▢ Ankle swelling
- ▢ Poor circulation
- ▢ Stroke/CVA
- ▢ Pacemaker or similar device
- ▢ Heart Disease
- ▢ Other:_____

Respiratory

- ▢ Chronic cough
- ▢ Shortness of breath
- ▢ Bronchitis
- ▢ Asthma - Mild Moderate Severe
- ▢ Emphysema
- ▢ Difficulty breathing
- ▢ Colds/Flu often
- ▢ Smoking (Duration:_____)
- ▢ Other:_____

Skin

- ▢ **Allergy to oil/lotion**
- ▢ Sensitivity
- ▢ Bruise easily
- ▢ Plantar Warts
- ▢ Contagious condition

_____

- ▢ Other:_____

Digestive/Urogenital

- ▢ Difficult digestion
- ▢ Constipation
- ▢ Diarrhea
- ▢ Liver/Gall bladder
- ▢ Kidney/Bladder
- ▢ Diabetes - Type:_____
- ▢ Painful/Difficult urination
- ▢ Blood in urine
- ▢ Prostate problem
- ▢ Stones
- ▢ Kidney/Bladder infection
- ▢ Other:_____

Gastrointestinal

- ▢ Poor/Excessive Appetite
- ▢ Indigestions
- ▢ Stomach pain/ulcer/hernia
- ▢ Nausea/Vomiting/Blood
- ▢ Irritable Bowel Disease
- ▢ Other:_____

Infections

- ▢ Hepatitis
- ▢ Skin conditions:_____
- ▢ TB
- ▢ HIV
- ▢ Herpes
- ▢ Other:_____

Head/Neck

- ▢ History of headaches
- ▢ History of migraines
- ▢ Vision problems
- ▢ Vision loss
- ▢ Hearing problems
- ▢ Hearing loss
- ▢ Other:_____

Other

- ▢ Osteoporosis
- ▢ loss of sensation:_____
- ▢ allergies:_____
- ▢ epilepsy
- ▢ cancer, where?_____
- ▢ Arthritis - Type:_____
- ▢ Sleep duration:_____
- ▢ Sleep quality:_____
- ▢ Sleeping position:
  Front ▢ Back ▢ Side ▢

Muscle/Joint Pains

- ▢ Neck
- ▢ Shoulders - Right/Left
- ▢ Back - Upper/Mid/Lower
- ▢ Legs - Right/Left
- ▢ Knee - Right/Left
- ▢ Arms - Right/Left
- ▢ Other:_____

For Pregnant Women

- ▢ First Trimester
- ▢ Second Trimester
- ▢ Third Trimester

History

- ▢ First Pregnancy
- ▢ Third Pregnancy
- ▢ Second Pregnancy
- ▢ Fourth Pregnancy
- ▢ First Birth
- ▢ Second Birth
- ▢ Third Birth
- ▢ Fourth Birth +

Is your pregnancy considered high risk? Are you experiencing any complications?

_____

_____

Prenatal Care Provider

Name_____

Number_____

Is there a family history of any conditions?

_____

_____

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Lifestyle History

Circle the most appropriate below:

Work Activity	Sitting	Standing	Light Labour	Heavy Labour
Exercise Activity	Never	Occasionally	Regularly	Often
Caffeine	Never	Occasionally	Moderate	Heavy
Cigarettes	Never	Occasionally	Moderate	Heavy
Stress	Never	Occasionally	Moderate	Heavy
Alcohol	Never	Occasionally	Moderate	Heavy
Diet	Very Good	Good	Average	Poor

If you exercise:

Type: _____

Frequency:_____

Duration:_____

Intensity:_____

Symptoms

Fill in this section if you are currently experiencing any pain or discomfort:

Is this discomfort due to a particular event, such as an accident or trauma? If yes, please indicate what happened and when it occured?

What Symptoms are you experiencing?

How long have you been experiencing these symptoms?

Does it interfere with your Work ▢ Sleep ▢ Sitting ▢ Standing ▢ Daily Routine ▢ Recreation ▢ Walking ▢ Bending ▢ Lying down ▢ Other

What is the intensity of your discomfort? ▢ Mild ▢ Moderate ▢ Severe

How often do you feel this discomfort? ▢ Constantly ▢ Intermittently ▢ With certain motions (please describe)

What makes your condition worse?

What makes your condition better?

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MAIA Questionnaire

The multidimensional assessment of introspective awareness questionnaire is a tool to assess your subjective experience of interoception, the sense of internal awareness. Below you will find a list of statements. Please indicate how often each statement applies to you generally in daily life, from 0 (never) to 5 (always):

When I am tense I notice where the tension is located in my body 1 2 3 4 5

I notice when I am uncomfortable in my body 1 2 3 4 5

I notice where in my body I am comfortable 1 2 3 4 5

I notice changes in my breathing, such as whether it slows down or speeds up 1 2 3 4 5

I do not notice (I ignore) physical tension or discomfort until they become more severe 1 2 3 4 5

I distract myself from sensations of discomfort 1 2 3 4 5

When I feel pain or discomfort, I try to power through it 1 2 3 4 5

When I feel physical pain I become upset 1 2 3 4 5

I start to worry that something is wrong if I feel any discomfort 1 2 3 4 5

I can notice an unpleasant body sensation without worrying about it 1 2 3 4 5

I can pay attention to my breath without being distracted by things happening around me 1 2 3 4 5

I can maintain awareness of my inner bodily sensations even when there is a lot going on around me 1 2 3 4 5

When I am in conversation with someone, I can pay attention to my posture 1 2 3 4 5

I can return awareness to my body if I am distracted 1 2 3 4 5

I can refocus my attention from thinking to sensing my body 1 2 3 4 5

I can maintain awareness of my whole body even when a part of me is in pain or discomfort 1 2 3 4 5

I am able to consciously focus on my body as a whole 1 2 3 4 5

I notice how my body changes when I am angry 1 2 3 4 5

When something is wrong in my life I can feel it in my body 1 2 3 4 5

I notice that my body feels different after a peaceful experience 1 2 3 4 5

I notice that my breathing becomes free and easy when I feel comfortable 1 2 3 4 5

I notice how my body changes when I feel happy/joyful 1 2 3 4 5

When I feel overwhelmed I can find a calm place inside 1 2 3 4 5

When I bring awareness to my body I feel a sense of calm 1 2 3 4 5

I can use my breath to reduce tension 1 2 3 4 5

When I am caught up in thoughts, I can calm my mind by focusing on my body/breath 1 2 3 4 5

I listen for information from my body about my emotional state 1 2 3 4 5

When I am upset I take time to explore how my body feels 1 2 3 4 5

I listen to my body to inform me about what to do 1 2 3 4 5

I am at home in my body 1 2 3 4 5

I feel my body is a safe place 1 2 3 4 5

I trust my body sensations 1 2 3 4 5

Consent

If I experience any pain or discomfort during my session, I will immediately inform the practitioner so that the treatment/training may be adjusted to my level of comfort. I further understand that bodywork/training should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand that training/bodywork practitioners are not qualified to perform spinal or skeletal adjustments or diagnose any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because bodywork/training should not be performed under certain medical conditions, I confirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep Motion Mekanics updated as to any changes in my medical profile and understand that there shall be no liability on Motion Mekanics' part should I fail to do so.

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of my session, and I will be liable for payment of the scheduled appointment.

Understanding all of this, I give my consent to receive care.

Signed _____ Date _____

Name: _____