



Integrated Movement and Post Rehabilitation Services Client Questionnaire

Name: _____ **Date:** _____
Address: _____
Phone #: _____(home/cell) _____(work)
Email address: _____
Birth date: _____ Age: _____ Sex: M F
Emergency Contact: _____ Relationship: _____
Phone #: _____(home/cell) _____(work)
Physician's Name: _____ Phone: _____
Chiropractor's Name: _____ Phone: _____
Physiotherapist's Name: _____ Phone: _____
Massage Therapist Name: _____ Phone: _____
Other? _____ Phone: _____

PAR-Q FORM – Physical Activity Readiness Questionnaire

Please read the following questions and answer each one honestly. Common sense is your best guide when answering these questions. Check YES or NO.

1. Has your doctor ever said you have any cardiovascular problems? **Yes No**
2. Do you frequently have pains in your chest when performing physical activity? **Yes No**
3. Have you had chest pains when you were not doing physical activity? **Yes No**
4. Do you lose your balance due to dizziness or do you ever lose consciousness? **Yes No**
5. Do you have a bone or joint problem (such as arthritis) that has been aggravated by or might be aggravated by exercise? **Yes No**
6. Are you pregnant or have you given birth within the last 3 months? **Yes No**
7. Are you over age 65 and not accustomed to a regular exercise? **Yes No**
8. Are you diabetic? **Yes No**
9. Do you know of any other reason why you should not be physically active? **Yes No**

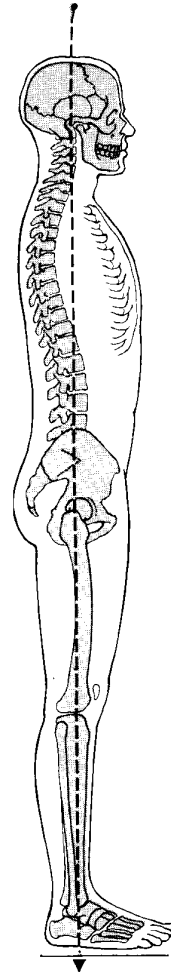
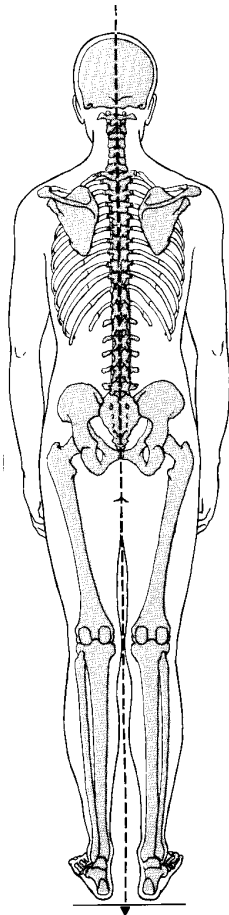
Medical Information

1. Date of last physician visit: _____
2. Are you currently taking any medications? Yes No
If yes, please list and explain the reasons for which they were prescribed. _____

3. Have you had any surgeries? Yes No
If yes, please list and describe, including month and year. _____

4. Describe your condition. What is your chief complaint? _____

5. Please circle where your pain is located on the diagrams below:



6. Please circle the level of your pain on the scale below:

1-----2-----3-----4-----5-----6-----7-----8-----9-----10

No pain

Persistent pain

Extreme pain

7. What is your occupation? _____

8. How many hours per week do you work? n/a 20 30 40 >40

9. What activities or postures are you required to maintain most hours in a typical day?

Sitting Standing Carrying loads Driving Walking

10. Have you been involved in an exercise program over the past year? If yes, what did it involve? _____

If no, how long have you been inactive? _____

11. What goals do you hope to achieve from this program? _____

I, _____, verify that the information provided above is accurate.

Signature: _____ Date: _____

Note: 24 hours notice is required when cancelling an appointment. Should I cancel an appointment with LESS than 24 hrs prior notice, I will be charged in full for that session.

I have read and understood this policy: _____(initial)



INFORMED CONSENT FORM

Thank you for choosing to use the activities, programs or services of the Natural Movement Centre. We request your understanding and cooperation in maintaining your safety and health by reading and signing the following INFORMED CONSENT AGREEMENT.

I, _____, declare that I intend to use some or all of the activities, facilities, programs, and services (herein after called "Activities") offered by the Natural Movement Centre and I understand that each person (myself included), has a different capacity for participating in such Activities. I am aware that all Activities offered are either educational, recreational or self-directed in nature. I assume full responsibility during and after my participation in such Activities and for my choices to use or apply, at my own risk, any portion of the information or instruction I receive.

I understand that part of the risk involved in undertaking any of the Activities is relative to my own state of fitness or health (physical, mental or emotional) and the awareness, care and skill with which I conduct myself in any of the Activities of the Natural Movement Centre. In addition, I understand that I am free to withdraw from, reduce or modify my involvement in any of the activities and I realize that I should do so on recognition of any signs of physical discomfort which may include: transient lightheadedness, fainting, chest discomfort, leg cramps, nausea, etc.

I further understand that the possible risks involved in participating in a fitness training program may include: muscle, tendon, ligament, bone and joint soreness, muscles, tendon and ligament strain, tear or rip, bruising, skin lacerations, tears, cuts or punctures, shortness of breath, dizziness, fainting or unconsciousness, tightness in chest, bone breaks, discoloration, separations, or fractures, fatigue, sweating, eye punctures, heart attack, stroke, or even death, aggravation of an existing or past injury, discomfort, or problem with any other injury, discomfort or physical problem associated with physical activity.

I have read the above list of possible risks associated with the fitness program developed and implemented by the certified Medical Exercise Specialist/Personal Trainer, Blaise Eagleheart, of the Natural Movement Centre. _____ (initial)

I consent to taking all of the above noted risks by VOLUNTARILY PARTICIPATING in the fitness program designed and implemented by the certified Medical exercise Specialist/Personal Trainer Blaise Eagleheart of the Natural Movement Centre.
_____ (initial)

I declare that I have read, understood and agree to the contents of this INFORMED CONSENT AGREEMENT in its entirety.

Participant: _____ Date: _____

Parent/Guardian (if under 18): _____ Date: _____

Witness: _____ Date: _____

(adapted from Fitness Standards Safety Committee, "Safety Standards from the screening of Participants Planning to Engage in Activities and Programs Offered by the Ontario Fitness Industry". Third draft, January 1989, p.7)

