Katlyn Sinclair, HBK, Registered Kinesiologist Superior Kinesiology
Unit 4 – 570 Red River Road
Thunder Bay, ON P7B 1H3
Phone: 807-345-8887 **Fax**: 807-345-6717

CLIENT INTAKE FORM

PATIENT INFORMATION

_____

FIRST NAME LAST NAME MALE / FEMALE / N/A

_____

ADDRESS CITY PROVINCE POSTAL CODE

DATE OF BIRTH (DD/MM/YYYY) _____/_____/_____

HOME # _____ CELL #_____ WORK #_____

EMAIL ADDRESS_____

CONSENT FOR CLIENT TO SEND EMAILS YES NO

HAVE YOU EVER SEEN A KINESIOLOGIST? YES NO LAST VISIT_____

MEDICAL DOCTOR_____

NAME OF PERSON THAT REFERRED YOU_____

IS YOUR INJURY THE RESULT OF A MOTOR VEHICLE ACCIDENT? YES NO

IS YOUR INJURY THE RESULT OF A WORKPLACE INJURY? YES NO

DO YOU HAVE EXTENDED HEALTH BENEFITS? YES NO

PRIMARY PLAN_____

POLICY #_____ ID#_____

POLICY MEMBER NAME_____ DOB_____

EMERGENCY CONTACT_____

PHONE NUMBER_____

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PRESENT CONDITION

Describe your major complaint:		
How did this happen? (accident/injury **or** repetition **or** unknown)		
When did this happen?	**Has this ever happened before?**	
How would you describe your symptoms? (please circle what applies to you)		
Sharp	Stabbing	Dull
Numb	Muscle spasm	Achy
Shooting	Weakness	Stiffness
Tingling	Burning	throbbing
Other:		
What alleviates your symptoms?	**What aggravates your symptoms?**	
Does the pain radiate (travel) anywhere?	**How often do you experience symptoms?**	
Have you previously received treatment for this injury/issue? (If yes, Where?)		
Have you obtained X-rays, MRI, EMG, CT scans or Lab work? (If yes, when and where)		

LIFESTYLE AND MEDICAL INFORMAITON

Do you Exercise? YES NO **If yes, please describe**_____

Occupation Title_____ **Name of Employer**_____

General description of your diet (be honest) _____

Current medications_____

High Stress? YES NO **If yes, please explain** _____

Please list any injuries and/or surgeries you have had: