Kinesiology Services
Zoé Arsenault
HBSc Kinesiology

SUPERIOR KINESIOLOGY

Unit 4 – 570 Red River Road
Thunder Bay, Ontario
P7B 1H3
Phone 807.345.8887

Client Intake Form

Personal Information		
Name:		Date:
Address:		
City:	Province:	Postal Code:
Home Phone:	Cell Phone:	Work Phone:
E-mail Address:		
Marital Status:	Family Doctor:	
Date of Birth:	Occupation:	Employer:
Extended Health Care Company:		Policy #:
How were you referred to us?		
Is your injury the result of a motor vehicle accident?		
Is your injury the result of a workplace injury?		
Emergency Contact:		Phone Number:

Present Condition History	
Describe your major complaint:	
How did this happen?	When did this happen?
Has this ever happened before?	How would you rate the pain / severity? /10

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How would you describe the symptoms? • Sharp • Numb • Shooting • Other:	• Tingling • Stabbing • Spasm	• Weakness • Burning • Dull	• Achy • Stiffness • Throbbing
What alleviates your symptoms?		What aggravates your symptoms?	
Does the pain radiate or travel anywhere? • No • Yes:		How often do you experience symptoms? • Rarely • Intermittently	• Frequently • Constantly
Have you previously received treatment for this issue/condition? • No • Yes, I have received:			
Have you obtained x-rays, MRI, EMG, CT scans, or lab work? • No • Yes, I have obtained:			

Health History & Medical Information		
Have you been hospitalized within the past 5 years?	• Yes • No	If Yes, please explain:
Have you ever had surgery?	• Yes • No	If Yes, please explain:
Have you ever suffered major physical trauma?	• Yes • No	If Yes, please explain:
Have you ever suffered a broken bone?	• Yes • No	If Yes, please explain:
Are you currently or have you ever suffered from:		

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- Abnormal weight loss/gain
- AIDS
- Allergies
- Alcoholism
- Anemia
- Arteriosclerosis
- Arthritis
- Arrhythmia
- Asthma
- Autoimmune disease
- Bleeding disorders
- Bronchitis
- Bulimia
- Bruise Easily
- Cancer
- Chest pain
- Congestive Heart Disease
- Cold extremities
- Constipation
- COPD/Emphysema
- CVA (Stroke/TIA)
- Dementia / Alzheimer's
- Depression
- Diabetes
- Digestion problems
- Dizziness
- Diagnosed emotional/mental disorders Dizziness
- Epilepsy
- Fatigue
- Fractures
- Fibromyalgia
- Gall Bladder Disease
- Glaucoma
- Goiter
- Gout
- Hepatitis
- High Blood Pressure
- High Cholesterol
- Hot flashes
- Kidney Disease
- Liver Disease / Cirrhosis
- Loss of Balance
- Migraines
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Osteoporosis
- Pacemaker
- Parkinson's
- Pinched Nerve Pneumonia
- Polio
- Prostate Problems
- Prosthesis
- Psychiatric Care
- Rheumatoid Arthritis
- Sciatica
- Seizures
- Sinus Infection
- Sleep Problems/Insomnia
- Skin Sensitivity
- Swollen Joints
- Thyroid condition
- Tuberculosis
- Tumors/Growths
- Typhoid Fever
- Ulcers
- Varicose veins
- Whooping Cough
- Other:

Family History: Please indicate those conditions which are suffered by blood relatives

- Anemia
- Atherosclerosis
- Arthritis
- Asthma
- Back ache
- Cancer
- Diabetes
- Disc disorder
- Emphysema
- Epilepsy
- Glaucoma
- Headaches
- Heart trouble
- High blood pressure
- High cholesterol
- Multiple sclerosis
- Osteoporosis
- Stroke
- Thyroid disease
- Other:

Medications: Please list any medications you are taking and why

Type: Reason:

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Kinesiology Informed Consent

- I must inform this office of any other practitioner other than physicians that are currently treating me
- I must inform my therapist of any contagious or infectious condition that I might have
- I understand that I need to express all of my health concerns both current and past to my therapist
- I consent to an examination and treatment performed by a certified Kinesiologist. The results will assist the Kinesiologist in determining the appropriate physical treatment to meet my specific needs and goals
- I understand that my treatment in this clinic may involve the use of:
    - Various physical and electrical modalities
    - Stretching or mobilization of joints and/or tissues
    - Exercise programs aimed at mobility, strength, and function
- I understand that discomfort may occur following treatment. The therapist will contact my physician should the presence of symptoms represent any potential risks. I understand that it is my responsibility to contact a therapist in the clinic should I experience any unusual symptoms.
- I understand that if at any time I am not comfortable with and/or do not understand the purpose of any treatment procedure I will ask the Kinesiologist for further explanation/information.
- I understand that I may stop the assessment or treatment procedure at any time during or after a session.
- I understand that the clinic will send an initial assessment and follow-up reports as appropriate to the licensed practitioner who referred me to the clinic for treatment.
- I have read, understood, and had an opportunity to discuss the client information form.

Fees for Kinesiology services are as follows:

- Initial assessment: $90.00
- Subsequent treatments: $50.00

My signature below indicates my understanding of all the above information.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date

If under 16 years of age, the following section of the consent form must be completed by a parent or guardian before treatment can be initiated.

I have read fully and understand all of the above information and give my permission to have _____ assessed and/or treated at Zoé Arsenault Kinesiology.

_____ _____ _____
Printed Name of Parent/Guardian Signature of Parent/Guardian Date