

## CHIROPRACTIC INTAKE FORM

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Weight (lbs): \_\_\_\_\_ Height (ft): \_\_\_\_\_  
Year—Month— Day

Marital Status: S M D W Other

Spouse's Name: \_\_\_\_\_ Children: \_\_\_\_\_

Emergency Contact Name & Number: \_\_\_\_\_

**Referred By: (Circle One)** Friend / Family \_\_\_\_\_  
Name  
Family Doctor      Massage Therapist      Physiotherapist  
Phone Book      Sign      Other

### PREVIOUS CHIROPRACTIC CARE:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of Last Treatment: \_\_\_\_\_

Results: \_\_\_\_\_

X-rays Taken?      Yes      No      Date: \_\_\_\_\_

### MEDICAL DOCTOR:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Last Appointment: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

## NUTRITION QUESTIONNAIRE

Please complete the questionnaire and Par-Q and return to Endurance on 8<sup>th</sup> Health Centre

### Personal Information:

This information will provide us with an overview of your current fitness level, previous history and future needs and goals.

Are you a smoker: Y/N

Stress level: (1: no stress, 5: high stress) 1 2 3 4 5

How satisfied are you with your current state of health? (1: not, 5: highly satisfied) 1 2 3 4 5

How satisfied are you with your current state of energy? (1: not, 5: highly satisfied) 1 2 3 4 5

### Physical Activity:

1. Do you find it difficult to participate in physical activity due to work or home commitments?  
Y/N
2. Do you regularly participate in a cardiovascular (aerobic) type program? Explain
3. Have you or are you participating in a resistance/strength/weight training program? Explain

### Goal Setting:

What is your motivation for having a meal plan and what are you hoping to accomplish?

What are your top 3 health/fitness/nutrition-related goals?

- 1.
- 2.
- 3.

How are you planning to achieve these goals? How will you measure your success?

Do you have any obstacles that may prevent you from achieving these goals? Y/N

**Additional Programming Information:**

Do you have any specific foods/activities that you would like to include in your program?

Do you have any health concerns, physical injuries, or food allergies/sensitivities?

Are you currently following a nutrition plan?

What time do you wake/go to bed?

Complete the following times and contents of your current meal plan.

- Breakfast @ \_\_\_\_\_ am. What is eaten (with approx measurements):

\_\_\_\_\_

- Snack #1 @ \_\_\_\_\_ am. What is eaten (with approx measurements):

\_\_\_\_\_

- Snack/Meal #2 @ \_\_\_\_\_ am/pm. What is eaten (with approx measurements):

\_\_\_\_\_

- Snack/Meal #3 @ \_\_\_\_\_ am/pm. What is eaten (with approx measurements):

\_\_\_\_\_

- Snack/Meal #4 @ \_\_\_\_\_ am/pm. What is eaten (with approx measurements):

\_\_\_\_\_

- Snack/Meal #5 @ \_\_\_\_\_ am/pm. What is eaten (with approx measurements):

\_\_\_\_\_

- Snack/Meal #6 @ \_\_\_\_\_ am/pm. What is eaten (with approx measurements):

\_\_\_\_\_

- Snack/Meal #7 (if applicable) @ \_\_\_\_\_ am/pm. What is eaten (with approx measurements):

\_\_\_\_\_

What is your exercise split (which muscle groups do you train and the specific days of the week you train them)?

What time of day do you typically weight train? For how long (in minutes)? What time of the day do you typically do cardio? What machine(s) are used (if any) and for how long (in minutes) and/or how many calories are burned?

What supplements are you currently consuming? Please list the specific time(s) of day you are consuming each product.

Have you experienced any hunger? If so, typically what time of the day/night are you the hungriest?

Are you tired/are your energy levels decreasing in any way? If so, when?

Do you experience any cravings and, if so, what time of the day/night?

Are you feeling overstuffed with food or are always in need of more?

What is your current weight?

What is your current body fat percentage?

What was your stage weight at your last competition?

What is the date (and time of day) of your upcoming competition/photo shoot? What category are you entering if this is for a physique competition?

## PAR-Q Physical Activity Readiness Questionnaire

Please complete the questionnaire below. Some people should check with their doctor before they start becoming much more physically active. Start by answering the seven questions below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and are not used to being very active, definitely check with your doctor first.

1. 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**
2. Do you feel pain in your chest when you do physical activity? **Y N**
3. In the past month, have you had chest pain when you were not doing physical activity? **Y N**
4. Do you lose your balance because of dizziness or do you ever lose consciousness? **Y N**
5. Do you have a bone or joint problem that could be made worse by a change in your physical activity? **Y N**
6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? **Y N**
7. Do you know of any other reason why you should not do physical activity? **Y N**

**If you answered YES** to one or more questions, talk with your doctor before you start becoming much more physically active.

**If you answered NO** to all questions, you can be reasonably sure that you can start becoming more physically active right now. Be sure to start slowly and progress gradually - this is the safest and easiest way to go.

NOTE: If the **PAR-Q** is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF PARENT or GUARDIAN (for participants under the age of majority)

\_\_\_\_\_

WITNESS NAME \_\_\_\_\_

WITNESS SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.**

**EXPLANATION OF ONLINE TRAINING AND NUTRITION FEES/INFORMED CONSENT**

The purpose of this page is to clarify your financial responsibilities so we can devote our efforts to helping you get the best results in the shortest amount of time.

Procedure	Fee
Initial Nutrition Plan	\$95.00
Initial Exercise Plan	\$95.00
Subsequent Nutrition Plan	\$75.00
Subsequent Exercise Plan	\$75.00
Combined Subsequent Nutrition/Exercise Plans	\$125.00

**Forms of Payment:**

Patients/Clients are responsible for full payment before services are rendered. We accept Visa and Mastercard.

Credit Card (Please circle one):  <p style="text-align: center;"><b>VISA    MASTERCARD</b></p>	Credit Card Number (Please Write Number and Expiry Date):
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**Online Training Package Terms (Read Carefully and Initial Each Term)**

\_\_\_\_\_ I agree that it is my responsibility to provide the requested weekly/biweekly/monthly updates (including photos) to Endurance on 8<sup>th</sup> Health Centre (via email) in order to receive my subsequent plan from Endurance on 8<sup>th</sup> Health Centre.

\_\_\_\_\_ I agree that I may not receive my plan(s) up to 7 business days from the last update provided to Endurance on 8<sup>th</sup> Health Centre.

\_\_\_\_\_ I understand my payment(s) also covers the extra hours Endurance on 8<sup>th</sup> Health Centre devotes to the construction of my custom made program.

\_\_\_\_\_ I agree there will be no refunds given for any services provided to me by Endurance on 8<sup>th</sup> Health Centre.

**I have read, understood, and agreed to the fees and payment obligations as listed above. I consent to the online services offered or recommended to me by Endurance on 8<sup>th</sup> Health Centre and intend this consent to apply to all my present and future online services at Endurance on 8<sup>th</sup> Health Centre.**

\_\_\_\_\_

Patient/Parent/Guardian Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Witness Signature

\_\_\_\_\_

Witness Name (Printed)