MCISAAC HEALTH
KINESIOLOGISTS

SCHEDULE B

PERSONAL/CONTACT INFORMATION

Date:	Physician Name:
Name:	Clinic Address:
Date of Birth:	Physician Number:
Cell# Work# Home#	
Email:	
Home Address:	

MEDICAL INFORMATION

Specialist	**Name**	**Company**	**Total Sessions**
Physiotherapist			
Chiropractor			
Osteopath			
Registered Massage Therapist			
Occupational Therapist			
Acupuncturist			
Kinesiologist			
Other:			

Please provide additional information regarding your reasons for seeing the above specialists:

Medical History and Present Medical Condition Questionnaire

Name: _____ Date: _____

In order for you to gain the most benefit from this program, we encourage you to answer all of the following questions. If you are uncomfortable with answering a particular question, feel free to leave it blank. Please explain all YES answers at the end of this questionnaire.

PERSONAL MEDICAL HISTORY

Have you have ever had any of the following conditions?

YES	NO		YES	NO		YES	NO	
☐	☐	1. Allergies	☐	☐	11. Ulcer	☐	☐	22. Epilepsy
☐	☐	2. Loss of hearing	☐	☐	12. Heart attack	☐	☐	23. Convulsions/seizures
☐	☐	3. Asthma	☐	☐	13. Heart murmur	☐	☐	24. Stroke
☐	☐	4. Kidney disease	☐	☐	14. Positive stress test	☐	☐	25. Diabetes
☐	☐	5. Prostatitis	☐	☐	15. Heart valve abnormality	☐	☐	26. Thyroid trouble
☐	☐	6. Colitis	☐	☐	16. Angina	☐	☐	27. Anemia
☐	☐	7. Hepatitis	☐	☐	17. Heart failure	☐	☐	28. Eczema
☐	☐	8. Liver disease	☐	☐	18. High cholesterol	☐	☐	29. Cancer (including skin cancer)
☐	☐	9. Elevated liver enzyme test	☐	☐	19. High blood pressure	☐	☐	30. Sleep apnea
☐	☐	10. Pancreatitis	☐	☐	20. Arthritis/rheumatism			
			☐	☐	21. Loss of consciousness			

REVIEW OF CONDITIONS

Do you currently have or have you recently had any of the following?

EYES, EARS, NOSE, THROAT

YES	NO	
☐	☐	31 Difficulty with night vision
☐	☐	32. Change in vision
☐	☐	33. Blurred or double vision
☐	☐	34. Bleeding gums
☐	☐	35. Frequent nosebleeds
☐	☐	36. Frequent sinus trouble
☐	☐	37. Recent hoarseness
☐	☐	38. Ringing/buzzing ears
☐	☐	39. Earaches

PULMONARY

YES	NO	
☐	☐	40. Shortness of breath
☐	☐	41. Chronic or frequent cough
☐	☐	42. Brown/blood-tinged sputum
☐	☐	43. Chest tightness
☐	☐	44. Wheezing

GENITO-URINARY

YES	NO	
☐	☐	45. Bladder trouble
☐	☐	46. Blood in urine
☐	☐	47. Irregular vaginal bleeding
☐	☐	48. Currently pregnant
☐	☐	49. Difficulty starting/stopping urination
☐	☐	50. Urinating 3 times per night
☐	☐	51. Frequent or painful urination
☐	☐	52. Problems with sexual function

GASTROINTESTINAL

YES	NO	
☐	☐	53. Vomited blood
☐	☐	54. Persistent diarrhea
☐	☐	55. Persistent constipation
☐	☐	56. Frequent abdominal pain
☐	☐	57. Frequent nausea
☐	☐	58. Frequent indigestion/heartburn
☐	☐	59. Black/bloody bowel movement
☐	☐	60. Hemorrhoids
☐	☐	61. Trouble swallowing
☐	☐	62. Hernia

CENTRAL NERVOUS SYSTEM

YES	NO	
☐	☐	63. Fainting spells
☐	☐	64. Recurrent dizziness
☐	☐	65. Frequent headaches
☐	☐	66. Tremors
☐	☐	67. Memory loss
☐	☐	68. Loss of coordination
☐	☐	69. Difficulty concentrating
☐	☐	70. Numbness/tingling extremities

HEART/VASCULAR

YES	NO	
☐	☐	71. Palpitation (irregular heartbeat)
☐	☐	72. Pain or discomfort in chest
☐	☐	73. High cholesterol
☐	☐	74. Swelling of feet
☐	☐	75. Leg pain while walking
☐	☐	76. Painful varicose veins

PERSONAL MEDICAL HISTORY

MUSCULOSKELETAL

YES	NO		
☐	☐	77.	Back trouble/pain
☐	☐	78.	Neck trouble/pain
☐	☐	79.	Joint injury/pain/swelling
☐	☐	80.	Carpal tunnel syndrome

MISCELLANEOUS

YES	NO		
☐	☐	81.	Bleeding/bruising easily
☐	☐	82.	Enlarged glands
☐	☐	83.	Rashes
☐	☐	84.	Unexplained lumps
☐	☐	85.	Chronic fatigue
☐	☐	86.	Night sweats
☐	☐	87.	Undesired weight loss
☐	☐	88.	Snoring
☐	☐	89.	Difficulty sleeping
☐	☐	90.	Low blood sugar

ADDITIONAL HEALTH AND LIFESTYLE QUESTIONS

Please answer the following questions honestly:

YES	NO		
☐	☐	91.	Are you experiencing any stresses, mood problems, relationship difficulties, or substance-related problems for which you would like resource or referral information on a confidential basis?
☐	☐	92.	Do you occasionally use or are you currently taking any prescription or over-the-counter medications? List name, dosage, and the reason the medication is used on the next page.
☐	☐	93.	Have you had any surgical operations in the last 10 years?
☐	☐	94.	Has anyone in your immediate family developed heart disease before the age of 60?
☐	☐	95.	Do any diseases run in your family?
☐	☐	96.	Do you currently have a cold/cough, or have you had any in the last two weeks?
☐	☐	97.	Have you ever been hospitalized? If yes, list date, length of stay, and reason on the next page.
☐	☐	98.	Are you currently under a doctor's care? If yes, list what you are being treated for on the next page.
☐	☐	100.	Have you had a change in the size or color of a mole, or a sore that would not heal in the past year?
☐	☐	101.	Do you have any special concerns regarding your health that you would like to discuss with the doctor?
☐	☐	102.	Are you a current cigarette smoker? A. How many packs of cigarettes do you smoke a day? _____ B. How long have you been smoking? _____
☐	☐	103.	Are you an ex-smoker? A. How many years did you smoke? _____ B. How many packs a day? _____ C. When did you quit? _____
☐	☐	104.	Have you used chewing tobacco or smoked cigars/pipe in the last 15 years?

105. I drink _____ beers; _____ ounces of hard liquor; _____ ounces of wine per week.

106. When were your most recent immunizations?

Tetanus _____ Flu shot _____ Pneumovax _____

107. When were you most recent health maintenance screening tests?

Cholesterol _____ Results? _____ PSA (Prostate) _____ Results? _____

Mammogram _____ Results? _____ Sigmoidoscopy _____ Results? _____

Pap smear _____ Results? _____

108. Describe any hobbies or recreational activities that have exposed you to noise, chemicals, or dust:

_____

_____

109. Please describe typical weekly exercise or physical activities including any exercise at work:

_____

110. My current diet could be best characterized as (check all that apply):

☐ Low-fat ☐ Low-carb ☐ High-protein ☐ Vegetarian/Vegan ☐ No special diet

Please explain all YES answers here. List the question number, and add details.

PERSONAL MEDICAL HISTORY

QUESTION NUMBER	DETAILS

COMPREHENSIVE CLIENT INFORMATION SHEET

On the following chart, fill in your approximate workout duration for each day (in minutes).

DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Duration							

Please submit your current exercise regimen along with this form (type it up or write it out for us).

Complete this section if you ARE NOT currently exercising regularly

If you are not currently exercising regularly, have you ever been on a consistent exercise plan (at least 3x per week)?

☐ Yes ☐ No

If you have exercised on a consistent basis previously, how long ago was this and how long did it last? _____

PART 5: MEDICAL AND HEALTH INFORMATION

If you have any diagnosed health problems, list the condition(s). _____

If you are on any medications, please list them. _____

What additional therapies or interventions are being undertaken for the given health problem(s)?

_____

If you have any injuries, please list them. _____

What additional therapies or interventions are being undertaken for the given injury(s)?

_____

PART 6: LIFESTYLE INFORMATION

What do you do for a living? _____

What is the activity level at your job?

☐ None (seated work only) ☐ Moderate (light activity such as walking) ☐ High (heavy labor, very active)

Does your job involve shift work?

☐ Yes ☐ No

If you follow a more regular schedule, do you work days, afternoons or nights? _____

Are you a primary caregiver for children, individuals with a disability, or an elder relative?

☐ Yes ☐ No

How often do you travel?

☐ Rarely ☐ A few times a year ☐ A few times a month ☐ Weekly

Please list the physical activities that you participate in outside of the gym and outside of work.

_____

_____

COMPREHENSIVE CLIENT INFORMATION SHEET

Please fill out the following timetable with your most normal daily schedule listing the time you wake up, work and have breaks, work out and go to sleep.

A.M.		P.M.	

Exactly how much money do you spend on groceries per month (provide amounts from your last two grocery bills)? _____

How many times per week do you shop for groceries? _____

How many meals do you eat in restaurants and/or fast food places per week? _____

Exactly how much money do you spend on supplements per month? _____

If you have any known food allergies, please list them below.

_____

Are there any other foods to which you're particularly sensitive (i.e., which cause excessive gas, bloating, stuffiness, or congestion)?

_____

SUBJECTIVE RECOVERY MEASURES

Please rate each item from 0-5:	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Sleep Quality: 0 = Poor Sleep 5 = Very Good Sleep							
Tiredness: 0 = No Tiredness 5 = Very Tired							
Willingness to Train: 0 = No Willingness 5 = Very Excited to Train							
Appetite: 0 = No Appetite 5 = Very Hungry							

GOALS

Please outline your goals below, from most important to least important:

1.

2.

3.

4.

5.

6.

ACTION PLAN (please leave blank):

Physical Activity Readiness
Questionnaire - PAR-Q
(revised 2002)

PAR-Q & YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box 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 you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO		
☐	☐	1.	**Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?**
☐	☐	2.	**Do you feel pain in your chest when you do physical activity?**
☐	☐	3.	**In the past month, have you had chest pain when you were not doing physical activity?**
☐	☐	4.	**Do you lose your balance because of dizziness or do you ever lose consciousness?**
☐	☐	5.	**Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?**
☐	☐	6.	**Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?**
☐	☐	7.	**Do you know of any other reason why you should not do physical activity?**

If you answered YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- if you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

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 _____

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.

Supported by: Health Canada Santé Canada