# NEW CLIENT HEALTH FORM

| | | |
|---|---|---|
| Participant Name: | Today's Date: | |
| Address: | Age: | Birth Date: / / |
| City: | Sex (Please circle): Male Female | |
| State, ZIP: | Phone (cell): | |
| Email: | Phone (home): | |
| Occupation or Sports with Positions (If applicable): | | |
| Emergency Contact: | Relationship to Contact: | |
| Emergency Contact Number: | | |
| Who can we thank for referring you to Kivett Kinetic Solutions? | | |

| YES | NO | N/A | MEDICAL HISTORY QUESTIONS |
|---|---|---|---|
| | | | Are you currently pregnant? |
| | | | Are you currently taking any blood thinners? |
| | | | Do you have a pacemaker? |
| | | | Do you currently have any form of cancer? |
| | | | Do you have a history of epilepsy or seizures? |
| | | | Are you diabetic or do you suffer from neuropathy? |
| | | | Do you have a history of DVT (Deep Vein Thrombosis)? |
| | | | Do you have any current skin infections (poison ivy, bacterial, herpes blisters, unknown rash)? |
| | | | Are you currently suffering from any bulged or herniated discs? |
| | | | Have you ever suffered from a stroke? |
| | | | Have you suffered from a head injury or concussion in the past 6 months? |

Please list any allergies (food, spices, medications, bees, latex, etc):

_____

_____

_____

Please list locations of any scars or tattoos on your body:

_____

_____

_____

NAME: _____ DATE: _____ AGE: _____

***ALL RESPONSES REMAIN CONFIDENTIAL AND ARE USED TO ASSIST IN DESIGNING YOUR PERSONAL PROGRAM TO PREVENT INJURY!***

| MUSCULOSKELETAL SCREENING | YES | NO | RIGHT/LEFT/DETAILS |
|---|---|---|---|
| Do you have pain in your arch or in the heel of either foot? | ☐ | ☐ | |
| Have you suffered a broken leg? | ☐ | ☐ | |
| Have you injured your ankles before? | ☐ | ☐ | |
| Are you a runner? | ☐ | ☐ | |
| Have you suffered a knee injury before? | ☐ | ☐ | |
| Do you have pain in your legs with sitting or standing? | ☐ | ☐ | |
| Do you have hip pain? | ☐ | ☐ | |
| Do you have a low back injury or have low back pain | ☐ | ☐ | |
| Do you have pain in your pelvis or lower abdomen? | ☐ | ☐ | |
| Do you have incontinence or have trouble using the bathroom? | ☐ | ☐ | |
| Do you have mid-back pain? | ☐ | ☐ | |
| Have you or do you currently have pain in your shoulder? | ☐ | ☐ | |
| Have you suffered a neck injury or have burning in your neck and shoulders? | ☐ | ☐ | |
| Do you often have a stiff neck? | ☐ | ☐ | |
| Do you have headaches regularly? | ☐ | ☐ | |
| If you are a female, have you had a hysterectomy? | ☐ | ☐ | |
| If you are a female, have you had a c-section? | ☐ | ☐ | |
| Have you or do you currently have a hernia? | ☐ | ☐ | |
| Do you have elbow pain or numbness/tingling in your arm/ elbow? | ☐ | ☐ | |
| Do you have numbness or tingling in your hands? | ☐ | ☐ | |
| Do you sit at a computer all day? | ☐ | ☐ | |
| Do you stand on your feet most of the day? | ☐ | ☐ | |
| Do you have trouble sleeping? | ☐ | ☐ | |
| Do you drive most of the day? | ☐ | ☐ | |
| Do you suffer from depression? | ☐ | ☐ | |
| Do you suffer from migraines? | ☐ | ☐ | |
| Do you suffer from water retention in your arms and legs? | ☐ | ☐ | |
| Do you have diabetes? | ☐ | ☐ | |
| Do you have high blood pressure? | ☐ | ☐ | |
| Do you fall short of breath with anything other than sitting? | ☐ | ☐ | |
| Have you ever had a seizure? | ☐ | ☐ | |
| Do you have asthma? | ☐ | ☐ | |
| Do you have osteoporosis or degenerative disc disease? | ☐ | ☐ | |
| If you are a female, are you currently pregnant? | ☐ | ☐ | |
| Do you suffer from anxiety? | ☐ | ☐ | |