Square One Active Recovery
13A Bukit Pasoh Road, 089827

Personal Information Date: ___/___/_____

Name: _____ NRIC: _____
Sex: Female/Male Date of Birth: ___/___/_____ Age: _____
Address: _____ Post Code: _____
Mobile: _____ Email: _____
Occupation: _____ Referred by: _____

Emergency Contact:
Name: _____ Relationship: _____
Contact: _____

Complaint #1:

1. Please tell us what your main complaint is. *Include as many details as possible.*

_____
_____

2. When and how did it begin? *Include month/year as well as the nature of incident.*

_____
_____

3. Are you able to tell us how this problem is affecting your life?

_____
_____

4. How often do you experience the symptoms?

☐ Constant (excluding sleep) ☐ Constant (wakes me up at night)
☐ Daily; _____ times per day ☐ Weekly; ☐ _____ days per week

5. Have you had similar symptoms in the past?

☐ Yes ☐ No

If yes, when was the last episode and how often do you experience the symptoms?

- My last episode was _____ days/months/years (please circle) ago.
- I experience the symptoms _____ times every _____ days/months years (please circle).

6. In your own words, what do you think is causing the problem?

_____
_____

7. Have your sought other care previously? How did it help?

Previous treatment	How did it help?
_____	_____
_____	_____
_____	_____
_____	_____

8. If you had to live with your symptoms as they are right now for the rest of your life, how would you feel about it?

0 1 2 3 4 5 6 7 8 9 10

Delighted Terrible

9. How determined are you to achieve a full recovery?

0 1 2 3 4 5 6 7 8 9 10

Not at all I will do whatever it takes

10. How confident are you of resuming usual/normal activities within six months?

0 1 2 3 4 5 6 7 8 9 10

Not confident at all Very confident

11. How confident are you of Square One helping you achieve your goals within six months?

0 1 2 3 4 5 6 7 8 9 10

Not confident at all Very confident

Using the SMART criteria, could you describe one or two goals that we could help you with?
Example 1: I'd like to run 2km without knee pain in four weeks time
Example 2: I'd like to reduce my pain to 1x/week lasting no longer than 30 minutes (per episode) in four weeks time.

Goal #1

_____
_____
_____

Goal #2

_____
_____
_____

Priorities

12. How important is each of the following for you

Improve overall health:

0 1 2 3 4 5 6 7 8 9 10

Not important Very important

Improve physical fitness:

0 1 2 3 4 5 6 7 8 9 10

Not important Very important

Reshape/tone my body:

0 1 2 3 4 5 6 7 8 9 10

Not important Very important

Improve my performance for a particular sports or at work:

0 1 2 3 4 5 6 7 8 9 10

Not important Very important

Improve mood or stress levels:

0 1 2 3 4 5 6 7 8 9 10

Not important Very important

Improve flexibility:

0 1 2 3 4 5 6 7 8 9 10

Not important Very important

Improve strength:

0 1 2 3 4 5 6 7 8 9 10

Not important Very important

Increase energy level:

0 1 2 3 4 5 6 7 8 9 10

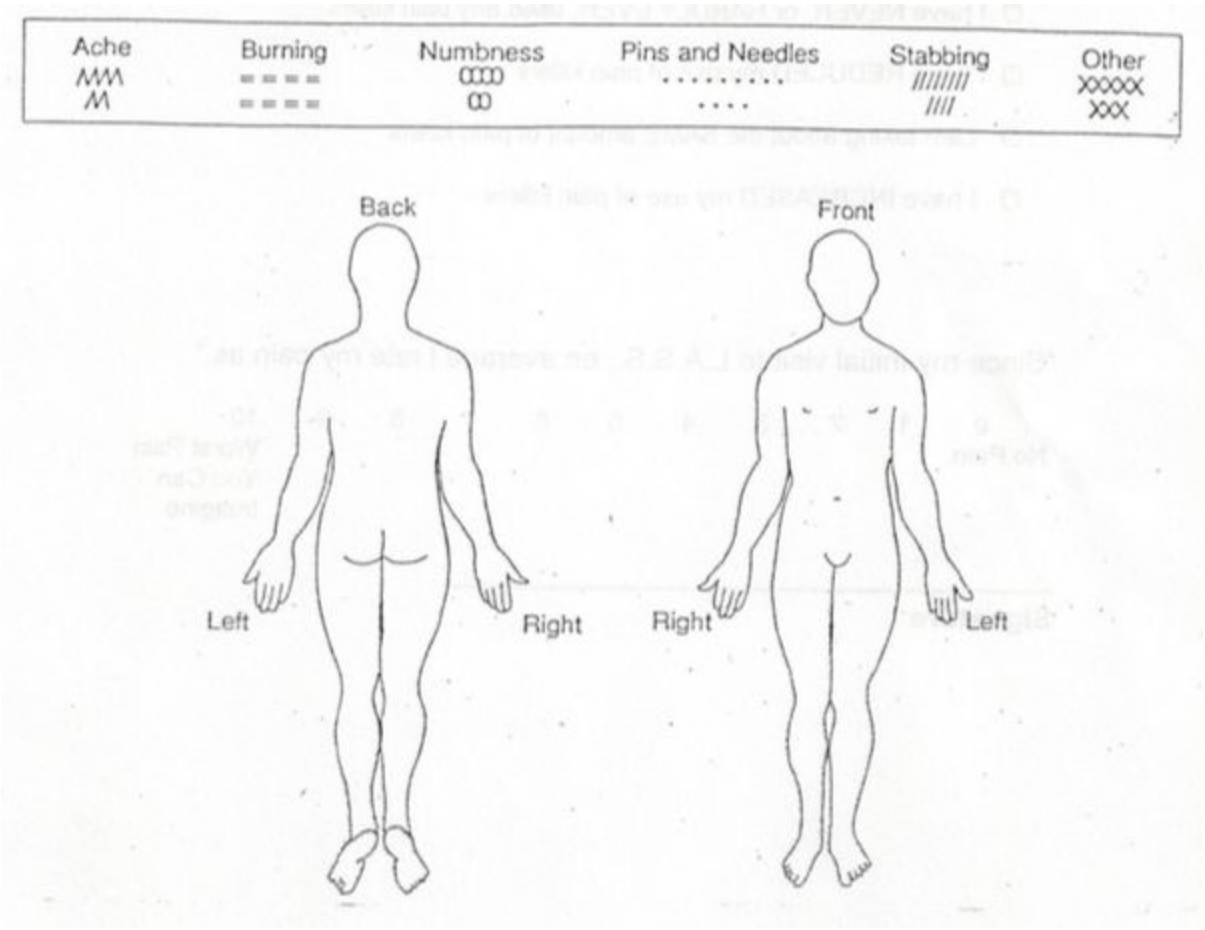
Not important Very important

Enjoyment:

0 1 2 3 4 5 6 7 8 9 10

Not important Very important

Pain Drawing



Health History

13. Have you experienced any of the following in the past month?

Dizziness, vertigo or unsteadiness	☐ Yes ☐ No
Loss of bodily movements, muscle control	☐ Yes ☐ No
Falls	☐ Yes ☐ No
Loss of consciousness, fainting	☐ Yes ☐ No
Visual disturbances	☐ Yes ☐ No
Difficulty speaking or swallowing	☐ Yes ☐ No
Nausea or vomiting	☐ Yes ☐ No
Numbness or tingling	☐ Yes ☐ No

14. What medications or supplements are you currently taking (if any)?

Name	Reason
_____	_____
_____	_____
_____	_____
_____	_____

15. Do you smoke?

☐ No, never
☐ No, in the past. I quit in _____ (year) after smoking for ____ years
☐ Yes, social (please circle) or _____ packet per day

16. Do you consume alcohol?

☐ No
☐ Yes, _____ standard drinks a week

17. Please list all (childhood inclusive) injuries, accidents, fractures, hospitalisation, surgeries you have had.

Year	Incident
_____	_____
_____	_____
_____	_____
_____	_____

18. Do you or your direct family members have any of the following?

Arthritis
☐ Self: diagnosed in ____ (year) ☐ Family: _____ (relationship), diagnosed in ____

Cancer
☐ Self: diagnosed in ____ (year) ☐ Family: _____ (relationship), diagnosed in ____

Kidney or Liver Disease
☐ Self: diagnosed in ____ (year) ☐ Family: _____ (relationship), diagnosed in ____

Hypoglycemia
☐ Self: diagnosed in ____ (year) ☐ Family: _____ (relationship), diagnosed in ____

Diabetes
☐ Self: diagnosed in ____ (year) ☐ Family: _____ (relationship), diagnosed in ____

Hypertension
☐ Self: diagnosed in ____ (year) ☐ Family: _____ (relationship), diagnosed in ____

Hypercholesterolemia
☐ Self: diagnosed in ____ (year) ☐ Family: _____ (relationship), diagnosed in ____

Heart Diseases
☐ Self: diagnosed in ____ (year) ☐ Family: _____ (relationship), diagnosed in ____

Osteoporosis/Osteopenia
☐ Self: diagnosed in ____ (year) ☐ Family: _____ (relationship), diagnosed in ____

Anxiety or Depression
☐ Self: diagnosed in ____ (year) ☐ Family: _____ (relationship), diagnosed in ____

Mental Illnesses
☐ Self: diagnosed in ____ (year) ☐ Family: _____ (relationship), diagnosed in ____

Exercise

19. In the past 12 months, how often have you participated in some kind of exercise?

☐ 3 to 4 times per week
☐ 1 to 2 times per week
☐ 1 to 2 times per month
☐ Not at all
☐ Others _____

20. What type of exercise do you enjoy and where do you go for exercise in the past?

Exercise	Where
_____	_____
_____	_____
_____	_____

21. What forms of exercise do you dislike. Why?

Exercise	Reason
_____	_____
_____	_____
_____	_____

Work Life

22. How many hours do you spend working a day? _____

23. Are you happy with your current work?

0	1	2	3	4	5	6	7	8	9	10
Delighted										Dissatisfied

24. In the past month, how would you rate your average stress level (within and outside work combined)?

0	1	2	3	4	5	6	7	8	9	10
None										Extremely high

25. In the past week, how would you rate your average stress level (within and outside work combined)?

0	1	2	3	4	5	6	7	8	9	10
None										Extremely high

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 _____ WITNESS _____
or GUARDIAN (for participants under the age of majority)

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.

Informed Consent

I understand that, as with any form of physical activity or exercise, orthopaedic, neurological, and physical performance testing carry with them a small inherent risk of injury which includes but is not limited to minor strains, intervertebral disc compromise, and compression fractures.

Initial here: _____

I understand that, as with any form of chiropractic, physical, manipulative, and exercise/rehabilitative therapies carry with them a small inherent risk of injury which includes but is not limited to minor strains, intervertebral disc compromise, and compression fractures.

Initial here: _____

I understand that, as with most healthcare interventions, there is a small (although rare) inherent risk of complication(s) associated with chiropractic, physical, manipulative, and exercise/rehabilitative procedures. These complications include, but are not limited to, muscle strains, dislocations, skin irritations, costovertebral sprains, fractures, disc trauma, and cardiovascular accidents. Initial here: _____

I understand my doctor/clinician will not be able to anticipate all potential complications, but elect to rely on his/her clinical expertise and judgment to determine courses of clinical action, based upon known facts, which are considered to be in my best interest.

Initial here: _____

I understand that results are not guaranteed and that I will have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time. Initial here: _____

I have read and understand the preceding statements, the nature and extent of the risks, and hereby consent to voluntarily participate in any orthopaedic, neurological, and physical/or performance testing as well as chiropractic, physical, manipulative, and/or exercise/rehabilitative therapies therapies as deemed appropriate by my doctor/clinician. I voluntarily accept all risks involved. Initial here: _____

I understand that I can withdraw my consent at any time should I become unwilling to engage in these procedures. I reserve the right to inform my doctor/clinician of such and not participate in these forms of evaluation or treatments. Initial here: _____

Name: _____ NRIC: _____

Signature: _____ Date: ___/___/_____