



Body Dynamics, L.L.C.

Body Dynamics Performance Studio
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Dynamic Performance Intake Form

Name: _____

Primary Goal / Sport: _____

If you are under 18 years of age, you must have your parent or legal guardian fill out the following information:

Parent/Guardian Name: _____ Primary Phone Number: _____

Parent/Guardian Address: _____

**Signature of Parent/Guardian required on Waiver Form.

FOR OFFICE USE ONLY:

Today' Date: _____

Class / Program: _____

Special Considerations or Restrictions: _____

Client / Athlete Information:

Name: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Date of Birth: ____/____/____ (mm/dd/yyyy) Age: ____ Gender: _____

How did you hear about Body Dynamics Performance Studio? _____

Physician / Specialist:

Name: _____ Phone: _____ Fax: _____

Medical Information:

Emergency Contact: _____ Relation: _____

Contact Phone Number(s): _____

Emergency Contact: _____ Relation: _____

Contact Phone Number(s): _____

Please list and describe any accidents &/or injuries you have had in the past. Please list any injuries that you may have currently: _____

Did you have any rehab for injuries listed above? If so, please explain type(s) and outcome of treatment. If no rehab was used, please explain reason for this. _____

Please list any surgeries (with dates) you have had or may be scheduled to have. _____

Have you ever been diagnosed with any of the following conditions? (Check all that apply)

Allergies		Infectious Diseases (i.e. Hepatitis, HIV, Tuberculosis)	
Arthritis		Joint Problems	
Broken Bones		Kidney Problems	
Blood Disorders		Lung Problems	
Cancer		Multiple Sclerosis	
Circulation / Vascular Problems		Osteoporosis	
Depression		Parkinson's Disease	
Diabetes		Rheumatoid Arthritis	
Epilepsy / Seizures		Stomach Problems	
Head Injuries		Stroke	
Heart Problems		Thyroid Problems	
High Blood Pressure		Other:	

Answer the following questions to the best of your knowledge.

		Yes	No
1	Have you had a medical illness or injury since your last physical? Any overnight hospitalization required?		
2	Are you currently taking any prescription or OTC medications?		
3	Have you taken any performance enhancing supplements or weight loss/gain products?		
4	Do you have any allergies?		
5	Have you ever passed out during or after exercise?		
6	Have you ever been dizzy during or after exercise?		
7	Do you tire more quickly than your friends / teammates do during exercise?		
8	Have you ever had racing heartbeats or skipped heartbeats?		
9	Have you ever been diagnosed with a heart murmur?		
10	Has a physician ever denied or restricted your participation in sports for any health reasons? (i.e. heart, breathing, injuries, etc)		
11	Do you have any skin problems? (i.e. itching, rash, warts, staph, etc)		
12	Have you ever had any head injuries or concussions?		
13	Have you ever been knocked unconscious or lost memory?		
14	Have you ever had a seizure?		
15	Do you have frequent or severe headaches?		
16	Have you ever had numbness or tingling in your arms, hands, legs or feet?		
17	Have you ever had a stinger or pinched nerve?		
18	Have you ever become ill from exercising in the heat?		
19	Do you cough, wheeze or have trouble breathing during or after an activity?		
20	Do you smoke cigarettes or cigars?		
21	Do you have asthma?		
22	Do you have seasonal allergies that require medical treatment?		
23	Do you have any known food allergies?		
24	Do you wear any special protective or corrective equipment or devices not usually used for your sport or position? (i.e. knee braces, neck rolls, hearing aids, etc)		
25	Have you had any problems with your eyes or vision?		
26	Have you ever had a sprain, strain or swelling after an injury?		
27	Have you ever broken or fractured any bones or dislocated any joints?		
28	Have you had any sizeable fluctuations in your weight?		
29	Does your goal(s) require you to maintain a specific weight or appearance?		
30	Does your activity or sport require you to lose weight regularly to meet weight requirements?		
31	Have you had any other problems with pain or swelling in bones, joints, muscles or tendons?		
32	Have you ever broken or fractured any bones or dislocated any joints?		
33	Do you ever feel stressed out?		
34	(Females) Have you ever missed your menstrual cycle?		
35	(Females) Have you ever given birth? <i>Natural or C-Section</i> (circle one)		

Sports History and Information

Sport(s): _____
 Coach: _____ Phone: (____) _____

Education:

Are you presently in school? YES NO
 If yes, which school are you presently attending? _____
 Grade: _____

Nutrition & Lifestyle

		YES		NO	
1	Do you grocery shop at least every 4 days?				
2	Do you eat more frozen/canned fruits and veggies than fresh?				
3	Do you eat more cooked veggies than raw?				
4	Do you eat veggies with less than 2 meals daily?				
5	Do you buy more non-organic veggies than organic veggies?				
6	Do you use a microwave oven during the week?	1-2x	3-4x	4+	
7	Do you eat quick cooked grains more than slow cooked organic whole grains?				
8	Do you eat white bread more often than whole grain breads?				
9	Do you drink pasteurized/homogenized milk, or eat cheeses frequently?	1-2x	3x	3+	
10	During the week, do you eat non-organic yogurts that are low fat, pre-sweetened or have fruit added?	1-2x	3x	3+	
11	Do you eat typical store brought eggs from cage-raised chickens?				
12	Do you eat red meat more than once every four days?				
13	Do you commonly eat meats (beef, chicken, turkey) from sources other than free-range and hormone-free source?				
14	Do you eat canned fish more frequently than fresh fish?				
15	During the week, do you use commercial salad dressings?	1x	2x	2+	
16	During the week, do you use Mayonnaise or products containing hydrogenated oils?	1x	2x	2+	
17	Do you eat nuts and/or seeds that are roasted and/or salted?				
18	During the week, do you use white table sugar as a sweetener?	1x	2-3x	3+	
19	During the week, do you use artificial sweeteners?	1x	2-3x	3+	
20	Do you use standard white table salt?				
21	Do you eat TV dinners or other highly processed foods more than 3 times / week?				
22	During the week, do you eat from fast food restaurants like McD's, B.K., etc?	1-2x	3x	3+	
23	Do you eat from vending machines?	1-2x	3x	3+	
24	Do you drink tap water?				
25	During the week, do you eat some form of store bought dessert, such as ice cream, cookies, donuts, cakes or pies after dinner most nights?	1x	2-3x	3+	

		YES		NO	
1	Do you eat more or less when stressed compared to not being stressed?				
2	Do you worry over job, income or money problems?				
3	Are any of your relationships causing you stress?				
4	Do you often feel anxious?				
5	Do you often feel upset when things go wrong or feel that things go wrong often?				
6	Do you lash out at others?				
7	Do you feel your sex drive is lower than normal for you?				
8	Do you feel stressed due to lack of intimacy in one or more relationships?				
9	Have you had reduced contact with friends (feeling antisocial) or an increase in contact because you feel you need to vent your frustrations or stresses to others?				
10	Do you feel isolated or suffer from loneliness?				
11	Do you take any form of medication prescribed by a physician directly or indirectly related to stress in your life or a psychological disorder?				
12	Do you lose more than two days of work a year due to illness?				

		YES		NO	
1	Do you live in the same time zone you were born in?				
2	Do you travel across time zones more than once a month?				
3	During the week, do you wake up feeling un-rested and in need of more sleep?	1x	3x	3+	
4	Do you commonly go to bed after 10:30 PM?				
5	Are the times you have bowel movements consistent and predictable on a daily basis?				
6	Do you suffer from reduced memory since moving to a new time zone or since traveling across time zones?				
7	Has your sense of hunger changed from being hungry at breakfast (upon rising), lunch (mid-day) and dinner times (sunset) since moving to a new time zone or traveling across time zones frequently (> 1 x / month)?				
8	During the week, do you wake up at night between 1AM and 4AM and have a hard time falling back asleep?				
9	During the week, do you tend to have a hard time staying awake after lunch?	1x	3x	3+	
10	Do you do shift work that requires you stay up late at night?				

		YES			NO	
1	Do you frequently skip meals?					
2	During the week, do you typically go more than 4 hours without eating?	1-2x	3x	3+		
3	During the week, do you sometimes skip breakfast?	2x	3x	3+		
4	Do you avoid fats when eating?					
5	Do you frequently eat carbs (i.e. breads, cookies, pasta, fruit, etc) by themselves?					
6	Do you get hungry or crave sweets within 2 hours after eating a meal					
7	Per day, do you use caffeine and/or sugar containing drinks (i.e. coffee, tea, sodas, fruit juices with sucrose, corn syrup or added sugar)?	1c	2c	2c+		
8	Have you tried diets to lose weight?	1x	2x	3-5x	5+	
9	Do you have difficulty burning fat around your belly, hips or thighs even with regular exercise?					
10	Do you eat your largest meal at night?					

		YES			NO	
1	During the week, do you experience lower abdominal bloating?	1-2x	3x	3+		
2	During the week, do you frequently have loose stools or diarrhea?	1x	3+			
3	Do you experience constipation or stools that are compact / hard to pass?	1-2x	3+			
4	Do you find that you often burp / belch after meals?					
5	Do you frequently have gas?					
6	Do you crave certain foods, such as bread, chocolate, certain fruits, and red meat, if you have not eaten them in a day or two?					
7	During the week, do you have a poor appetite and/or feel worse after eating?	1-2x	3x	3+		
8	Do you have an excessive appetite and/or sweet cravings?					
9	Do you frequently (more than 2x / wk) experience abdominal pain, cramps, or general abdominal discomfort?					
10	During the week, do you have indigestion, heartburn or upset stomach?	1-2x	3x	3+		
11	Do you get a headache after eating?	1-2x	3+			

		YES			NO	
1	Are your eyes sensitive to bright light?					
2	Do you suffer from irritability and have difficulty relaxing?					
3	Do you often feel fatigued and sluggish?					
4	During the week, do you suffer from frequent headaches?	1x	3+			
5	During the week, do you have dark circles and/or puffiness under eyes?	1x	2-3x	3+		
6	Are you sensitive to perfumes, paint fumes, traffic fumes, detergents or cigarette smoke?	mild	moderate	very		
7	Have you been unable to lose cellulite with diet and/or exercise?					
8	Are you currently, or have you in the past, been frequently exposed to industrial or agricultural chemicals, such as solvents, cleaning fluids, paint fumes, plant sprays and fertilizers?	brief	1+/wk	daily		
9	During the week, do you experience mental sluggishness, poor memory or poor concentration?	1-2x	3x	3+		
10	During the month, do you suffer from skin reactions such as rashes, itching or burning, for which the cause is unknown?	1-2x	3x	3+		

Waiver, Release, and Assumption of Risk Form

This is an important legal document. Its purpose is to explain the risks you are assuming by beginning an exercise program. It is highly advisable that you consult your physician prior to beginning any exercise program. It is critical that you read and understand this document completely. After you have done do, please print your name legibly and sign in the spaces provided below. Anyone under 18 years old must have parent or legal guardian sign this document as well.

The information gathered from this intake process, and any information gathered from the structural assessments and movement screens (dynamic movement, posture and static) are intended for information only. The information will be used to provide insight into any possible joint or movement dysfunctions, which may affect your ability to compete, function or train efficiently. The goal of the assessments is to assist in identifying movement asymmetries, muscles flexibility issues, strength asymmetries/imbbalances, joint restrictions/limitations, and muscle recruitment pattern dysfunctions. This assessment is in no way a substitute for a medical evaluation from a licensed physician. If you have any condition(s) that is beyond the scope of our practice, we will suggest that you consult a Physician for proper treatment.

1. I, _____ (name of participant), acknowledge that I have voluntarily elected to participate in an exercise program and/or dynamic assessment operated by Body Dynamics, L.L.C. I am aware that participation in the movement screens and program routines will require me to engage in vigorous physical activities. I am voluntarily participating in these activities with the knowledge that there are possible risks involved. I hereby assume all risks and hazards incidental to such participation in these activities. In consideration of Body Dynamics L.L.C. and Body Dynamics Performance Studio agreement to assist, coach, instruct and train me, I do here and forever release and discharge and hereby hold harmless Body Dynamics, L.L.C. and their respective agents, heirs, contractors and employees from any and all claims, damages, demands, rights of action or causes of action, present or future, arising out of or connected with my participation in this or any exercise program including and injuries resulting there from. THIS WAIVER AND RELEASE OF LIABILITY INCLUDES, WITHOUT LIMITATION, INJURIES WHICH MAY OCCUR AS A RESULT OF (1) EQUIPMENT THAT MAY MALFUNCTION OR BREAK (2) ANY SLIP, FALL, DROPPING OF EQUIPMENT AND (3) OUR NEGLIGENT INSTRUCTION OR SUPERVISION.
2. I, _____, recognize that exercise might be difficult and strenuous and that there could be dangers inherent in exercise for some individuals. I acknowledge that the possibility of certain unusual physical changes during exercise does exist. These changes include abnormal blood pressure; fainting; disorders in heartbeat; heart attack; and, in rare instances, death.
3. (If participant is a minor) I, the parent/legal guardian of the Participant hereby grant permission to the employees or representatives of Body Dynamics L.L.C. as well as any contractors of Body Dynamics Performance Studio to authorize and obtain medical care for the Participant from any licensed physician, hospital, or medical clinic should the Participant become injured or ill while participating in the activities at any other time when neither parent or legal guardian is available to grant authorization for emergency treatment.
4. I have carefully read this agreement before executing it and acknowledge that I am signing this agreement voluntarily and with the full intent of releasing Body Dynamics, L.L.C. from any and all claims arising as a result of my participation in the activities. I am waiving any rights or rights my successors may have to bring legal action or assert a claim against Body Dynamics, L.L.C. for your negligence or that of your employees, agents or contractors.

Print name of Participant

Signature of Participant

Date

Signature of Parent or Legal Guardian, if applicable

Date