



****Please answer each question in depth. This will help us better assist you on your health journey.*

1. What is your main reason for consulting with us?

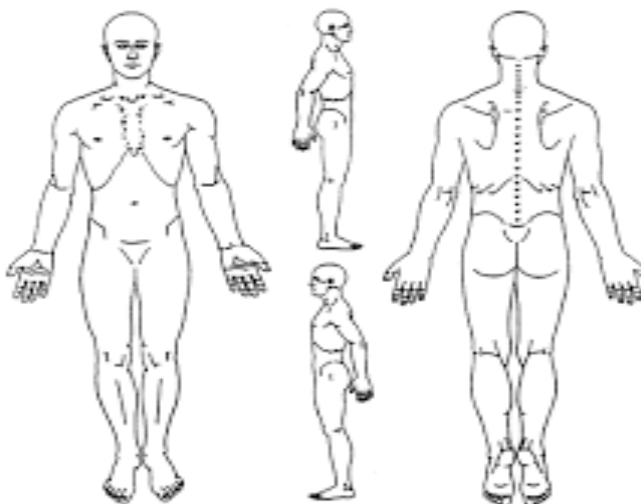
2. If you are currently experiencing pain or have an injury, please answer the following questions:

a. When did the pain/injury occur (date of occurrence)?

b. What activity were you doing when the pain/injury occurred?

c. What is your current pain level (0= no pain, 5= fair, 10= excruciating pain)?

d. Please mark where the pain/injury is. And state which parts of the body the pain refers to (if applicable).



e. Please describe how the pain currently feels like (local/radiating/dull ache/sharp/shooting/burning)?



f. What activities/movements makes the pain you're experiencing worse?

g. What activities/movements makes the pain you're experiencing less/better

h. Have you done any X-rays and/or MRIs for the pain/injury? Is yes, who is the doctor treating the pain/injury?

i. Are you taking any medication for the pain/injury, prescribed and over the counter?

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3. Please state any other injuries/pain you have had in the past. Did you receive any form of treatment (surgery, medication, physiotherapy, chiropractic treatment, alternative medicine) for the injury/pain? If yes, for how long did you receive treatment? And does the injury/pain still bother you?

4. Have you been diagnosed with a chronic condition, i.e.: High cholesterol, High blood pressure, diabetes, heart disease, stroke, etc.? if yes, which conditions and who is the doctor treating the condition?



5. Are you currently taking any chronic medication and/or supplements? If yes, please list them below

6. Have any of your family members been diagnosed with a chronic condition, i.e.: High cholesterol, High blood pressure, diabetes, heart disease, stroke, blood clotting, etc. (your immediate family up to level of your grandparents)? If yes, which conditions and who in the family?

7. What are your current daily habits?

a. What are you likely to have for breakfast, lunch, dinner, and snacks?

b. How many cups of water, coffee, and tea do you consume a day? How many teaspoons of sugar do you put in your coffee and tea? Do you take it with milk?

c. How many units of alcohol do you drink per week? If noy weekly, how often do you drink alcohol a year?

d. Do you use any of the following: tobacco/vape/drugs? If yes, which one and how often in a day/week?



- e. How is your overall sleep quality on a scale of 0-10 (0=bad, 5= fair, 10= amazing)? On average how many hours of sleep do you get each night?

- f. What do you do for a living? Does it require you to sit a lot?

- g. Do you generally experience any headaches? How often do you have a headache?

- h. How are your general stress levels on a scale on 0-10 (0= low, 5= fair, 10= high)? What exacerbates your stress, i.e.: work, family, studies, relationships, environment, illness, etc.?

- i. Do you experience any signs and symptoms of depression and anxiety, i.e.: changes in sleeping and/or eating habits, being tired during the day for no reason, loss of interest in life activities, excessive worrying, trouble relaxing, heart palpitations, irritable, on high alert all the time? If yes, how often do you experience them?

- j. Do you participate in any form of physical activity/exercise? What activities do you do? How often a week? For how long a session?

8. What treatment goals do you currently have?

BHSc (Biokinetics) with Honours (WITS)
Sports Massage Therapy (HFPA)
Short courses:
Medial Neuroscience, Nutrition and Health
HPSCA #: BK 0035327
PRACTICE #: 0981400



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Email: bmbio@reignitehealth.co.za
Website: reignitehealth.co.za
Facebook: Reignite Health
YouTube: Reignite Health

9. Are there any other injuries/pain/conditions you may have that we are able to assist you with? If yes, please specify what they are?
