

MINNESOTA DANCE MEDICINE

AT THE MINNESOTA SHUBERT PERFORMING ARTS & EDUCATION CENTER

~ PREVENTATIVE SCREENING FORM ~

PERSONAL HISTORY

NAME: _____ DATE OF BIRTH: ___/___/___

ADDRESS: _____ GENDER: (CIRCLE ONE) M / F

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: (HOME) _____ (WORK/VOICEMAIL) _____

(CELL) _____ (E-MAIL) _____

ETHNICITY

- AFRICAN/AMERICAN
- ASIAN
- CAUCASIAN
- HISPANIC
- OTHER: _____

MARITAL STATUS

- MARRIED
- SINGLE
- SEPARATED
- DIVORCED
- WIDOWED

- SCHOOL/COMPANY WHERE YOU PRIMARILY STUDY/PERFORM:

- HOW DID YOU HEAR ABOUT OUR FREE DANCE INJURY PREVENTION CLINIC?

TYPE OF DANCE YOU PRIMARILY STUDY

(CHECK ALL THAT APPLY)

- BALLET
- JAZZ
- MODERN*
- DANCE TEAM
 - HIGH KICK
 - JAZZ
- GYMNASTICS/TUMBLING
- OTHER: _____

CURRENT LEVEL OF TRAINING

(CHECK ALL THAT APPLY)

- PROFESSIONAL
- CHOREOGRAPHER
- TEACHER
- STUDENT

*IF YOU PRIMARILY STUDY **MODERN** DANCE, IDENTIFY THE TYPE OF MODERN TECHNIQUE YOU STUDY MOST OFTEN: _____

▪ HOW MANY HOURS OF CLASS DO YOU TAKE IN A TYPICAL **DAY**? _____ HOURS

▪ HOW MANY HOURS OF REHEARSAL DO YOU HAVE IN A TYPICAL **WEEK**? _____ HOURS

▪ HOW MANY PERFORMANCE WEEKS DO YOU HAVE IN A TYPICAL **YEAR**? _____ WEEKS

▪ DO YOU HAVE ANOTHER JOB(S) TO SUBSIDIZE YOUR DANCE LIFE?

(CIRCLE ONE) YES / NO

IF YES, DESCRIBE WHAT THAT JOB(S) IS: _____

▪ AT WHAT AGE DID YOU BEGIN SERIOUS DANCE TRAINING? _____ YEARS OLD

▪ DO YOU DO ANY OTHER FORM OF EXERCISE ON A REGULAR BASIS? (CIRCLE ONE)

YES / NO

IF YES, ANSWER THE FOLLOWING QUESTIONS:

• **TYPE** OF EXERCISE (I.E. WEIGHTLIFTING, AEROBICS, PILATES, YOGA, RUNNING, SWIMMING, BICYCLING):

• **FREQUENCY** (# OF TIMES PER WEEK YOU DO THIS OTHER EXERCISE): _____ TIMES PER WEEK

• **INTENSITY** ON A SCALE OF 1-10, (1=VERY EASY; 10=HARDEST EXERCISE POSSIBLE) HOW HARD IS YOUR EXERCISE PROGRAM FOR YOU TO DO? (CIRCLE ONE)

1 2 3 4 5 6 7 8 9 10

• **DURATION** (HOW LONG PER SESSION DO YOU TYPICALLY EXERCISE): _____ MINUTES PER SESSION

▪ DO YOU TRAIN EN POINTE? (CIRCLE ONE) YES / NO

IF YES, ANSWER THE FOLLOWING QUESTIONS:

• AT WHAT AGE DID YOU BEGIN POINTE WORK? _____ YEARS OLD

• HOW MANY HOURS PER DAY DO YOU TYPICALLY SPEND WORKING EN POINTE? _____ HOURS PER DAY

- ARE YOU CURRENTLY ON ANY MEDICATION (INCLUDING ASPIRIN, ADVIL, TYLENOL, ETC.)?

(CIRCLE ONE) YES / NO

IF YES, ANSWER THE FOLLOWING QUESTIONS:

- MEDICATION: _____
- HOW OFTEN? _____
- DOSAGE? _____
- FOR WHAT CONDITION? _____
- WHAT MEDICAL PROBLEMS RUN IN YOUR FAMILY? _____

- DO YOU SMOKE? (CIRCLE ONE) YES / NO

IF YES, ANSWER THE FOLLOWING QUESTIONS:

- HOW OFTEN? _____
- HOW MUCH? _____
- FOR HOW LONG? _____

- DO YOU DRINK ALCOHOL? (CIRCLE ONE) YES / NO

IF YES, ANSWER THE FOLLOWING QUESTIONS:

- HOW OFTEN? _____
- HOW MUCH? _____
- FOR HOW LONG? _____

- HAVE YOU EVER HAD SURGERY? (CIRCLE ONE) YES / NO

IF YES, ANSWER THE FOLLOWING QUESTIONS:

- WHY? _____
- WHEN? _____

- CURRENT HEIGHT _____ FOOT _____ INCHES

- AT WHAT AGE DID YOU ACHIEVE THIS HEIGHT? _____ YEARS OLD

- CURRENT WEIGHT: _____ POUNDS
 - HOW LONG HAVE YOU WEIGHED THIS MUCH? _____ YEARS
 - AT WHAT AGE DID YOU ACHIEVE THIS WEIGHT? _____ YEARS OLD
 - IS YOUR WEIGHT STABLE OR DOES IT FLUCTUATE? (CIRCLE ONE) STABLE / FLUCTUATES
 - DO YOU DIET TO MAINTAIN YOUR WEIGHT? (CIRCLE ONE) YES / NO
IF YES, DESCRIBE YOUR DIET TECHNIQUE: _____
 - ABOUT HOW MANY CALORIES DO YOU THINK YOU EAT IN A TYPICAL DAY? _____ CALORIES
 - GENERALLY, DO YOU FEEL YOU EAT WELL? (CIRCLE ONE) YES / NO
 - DO YOU TAKE VITAMIN SUPPLEMENTS? (CIRCLE ONE) YES / NO
 - GENERALLY, DO YOU FEEL YOU SLEEP WELL AND YOU SLEEP ENOUGH? (CIRCLE ONE) YES / NO
IF NO, EXPLAIN: _____
 - DO YOU TAKE CALCIUM SUPPLEMENTS? (CIRCLE ONE) YES / NO
 - ARE YOU SATISFIED WITH YOUR BODY WEIGHT? (CIRCLE ONE) YES / NO
IF NO, WHAT WEIGHT WOULD YOU PREFER TO BE? _____ POUNDS
 - DO YOU FEEL FATIGUED AND LACK OF ENERGY MOST DAYS? (CIRCLE ONE) YES / NO

▪ WHAT TYPE OF DANCE SHOES DO YOU MOST OFTEN TRAIN IN? (CHECK ONE)

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> NONE (BAREFOOT) | <input type="checkbox"/> JAZZ OXFORDS |
| <input type="checkbox"/> BALLET SLIPPERS | <input type="checkbox"/> POINTE SHOES |
| <input type="checkbox"/> CHARACTER SHOES | <input type="checkbox"/> OTHER: _____ |

▪ DO YOU WEAR ORTHOTICS IN YOUR SHOES? (CIRCLE ONE) YES / NO
IF YES, ANSWER THE FOLLOWING QUESTIONS:

- TYPE OF ORTHOTIC: _____
- FOR HOW LONG? _____
- DO YOU WEAR THEM (CIRCLE ONE):

IN ALL SHOES	IN DANCE SHOES ONLY	IN STREET SHOES ONLY
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▪ DO YOU DANCE ON SPRUNG WOOD FLOORS? (CIRCLE ONE)

ALWAYS USUALLY OFTEN SOMETIMES RARELY NEVER

- DO YOU WARM-UP BEFORE CLASS? (CIRCLE ONE)

ALWAYS

USUALLY

OFTEN

SOMETIMES

RARELY NEVER

- WHAT DOES YOUR WARM-UP CONSIST OF? _____

- DO YOU STRETCH AFTER CLASS OR EXERCISE? (CIRCLE ONE)

ALWAYS

USUALLY

OFTEN

SOMETIMES

RARELY NEVER

- DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS? (CHECK ALL THAT APPLY)

HEADACHES

NAUSEA

VOMITING

SEIZURES

HISTORY OF CANCER

FEVER

NIGHT SWEATS

FAINTING

DENTURES

HIGH BLOOD PRESSURE

CHRONIC COUGH

DIZZINESS

DIABETES
IF DIABETIC, DO YOU TAKE INSULIN? (CIRCLE ONE)

YES / NO

CONTACT LENSES

GLASSES

HEARING AIDS

PAIN (DESCRIBE: _____)

OTHER: _____

WOMEN

- AT WHAT AGE DID YOU GET YOUR MENSTRUAL PERIOD? _____ YEARS OLD

- IS YOUR PERIOD REGULAR (I.E. DO YOU GET IT EVERY 28-35 DAYS)? (CIRCLE ONE) YES / NO*

- HAS IT ALWAYS BEEN REGULAR? (CIRCLE ONE) YES / NO*

*IF NO TO EITHER OF THE ABOVE QUESTIONS, ANSWER THE FOLLOWING QUESTIONS:

• DESCRIBE YOUR CYCLE: _____

• DO YOU GO TO YOUR GYNECOLOGIST EVERY 6-12 MONTHS FOR A GENERAL CHECK-UP? (CIRCLE ONE)

YES / NO

• WHEN DID THIS IRREGULAR PATTERN BEGIN? _____

• DO YOU TAKE ORAL CONTRACEPTIVE (I.E. "THE PILL")? (CIRCLE ONE) YES / NO

MEN

- AT WHAT AGE DID YOU FIRST GET FACIAL HAIR (I.E. A BEARD)? _____ YEARS OLD

MEDICAL COMPLAINT

▪ WHAT IS THE INJURY/PROBLEM YOU ARE HERE FOR TODAY?

• PART(S) OF BODY: _____

• HOW DID THIS INJURY/PROBLEM HAPPEN? (CIRCLE ONE)

TRAUMATIC ACCIDENT / SLOW ONSET

• WHAT ARE YOUR CURRENT SYMPTOMS?

• HOW LONG HAVE YOU HAD THIS PROBLEM? _____ (CIRCLE ONE) YEARS / MONTHS / WEEKS / DAYS

• HAVE YOU HAD THIS SAME PROBLEM BEFORE? (CIRCLE ONE) YES / NO
IF YES, ANSWER THE FOLLOWING QUESTIONS:

• WHEN? _____

• HOW LONG DID IT LAST? _____

• WHAT MADE IT BETTER? _____

• HAVE YOU HAD PHYSICAL THERAPY OR OTHER MEDICAL TREATMENT OF ANY KIND FOR THIS PROBLEM?
(CIRCLE ONE) YES / NO

IF YES, DESCRIBE TREATMENT: _____

• DID YOU GET BETTER? (CIRCLE ONE) YES / NO

• WHAT OTHER INJURIES/PROBLEMS HAVE YOU HAD IN THE PAST?

• WHAT ARE YOUR GOALS OF TODAY'S VISIT?

