



Name: _____ Date of birth (Y/M/D): _____ Today's date: _____
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DANCER INTAKE FORM

1. What is your primary style of dance? _____
2. How long have you been dancing in your primary style? _____
3. What is your current company or dance academy/school? _____
4. How long have you been at this company/school? _____
5. For student dancers – do you compete in dance? Yes No
6. What other styles of dance do you do?
 1. _____ for _____ years
 2. _____ for _____ years
 3. _____ for _____ years
7. On average, how many hours per week do you **practice or rehearse**?

First style: _____ hours per week
 Second style: _____ hours per week
 Third style: _____ hours per week
 Fourth style: _____ hours per week
8. On average, how many hours per month do you **perform**?

First style: _____ hours per month
 Second style: _____ hours per month
 Third style: _____ hours per month
 Fourth style: _____ hours per month
9. Do you teach dance? Yes No
 If yes, how many hours a week do you teach? _____
10. Nightly sleep: Average of _____ hours of sleep per night
11. Please rate your nutrition by circling a number.

0 1 2 3 4 5 6 7 8 9 10
 Very unhealthy Very healthy

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12. Have you been diagnosed with an eating disorder? Yes No

13. Do you have concerns about your eating or weight? Yes No

If yes please provide some more details:

14. Do you have regular menstrual periods? Yes No

15. Do you smoke?

Never

In the past: _____ cigarettes per day/ _____ years of smoking

Yes, _____ cigarettes per day, for _____ years

16. Do you drink alcohol?

Never

Yes, an average of _____ glasses per week

17. Do you engage in other physical activity?

Never

Yes, an average of _____ hours per week

Which activity/ies?

18. Which other hobbies do you engage in regularly?

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Dance-related musculoskeletal problems are defined as "pain, weakness, numbness, tingling, or other symptoms that interfere with your ability to dance at the level to which you are accustomed". This definition does not include mild transient aches and pains.

19. Have you **ever** had pain/problems that have interfered with your ability to dance at the level to which you are accustomed? Yes No

If yes, please give details below:

Previous diagnosis/es: _____

How much have you recovered? _____%

Other comments: _____

PAST INJURIES

20. Have you had pain/problems that have interfered with your ability to dance at the level to which you are accustomed **during the last 12 months**? Yes No

21. Have you had pain/problems that have interfered with your ability to dance at the level to which you are accustomed **during the last month (4 weeks)**? Yes No

22. **Currently (in the past 7 days)**, do you have pain/problems that have interfered with your ability to dance at the level to which you are accustomed? Yes No



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all

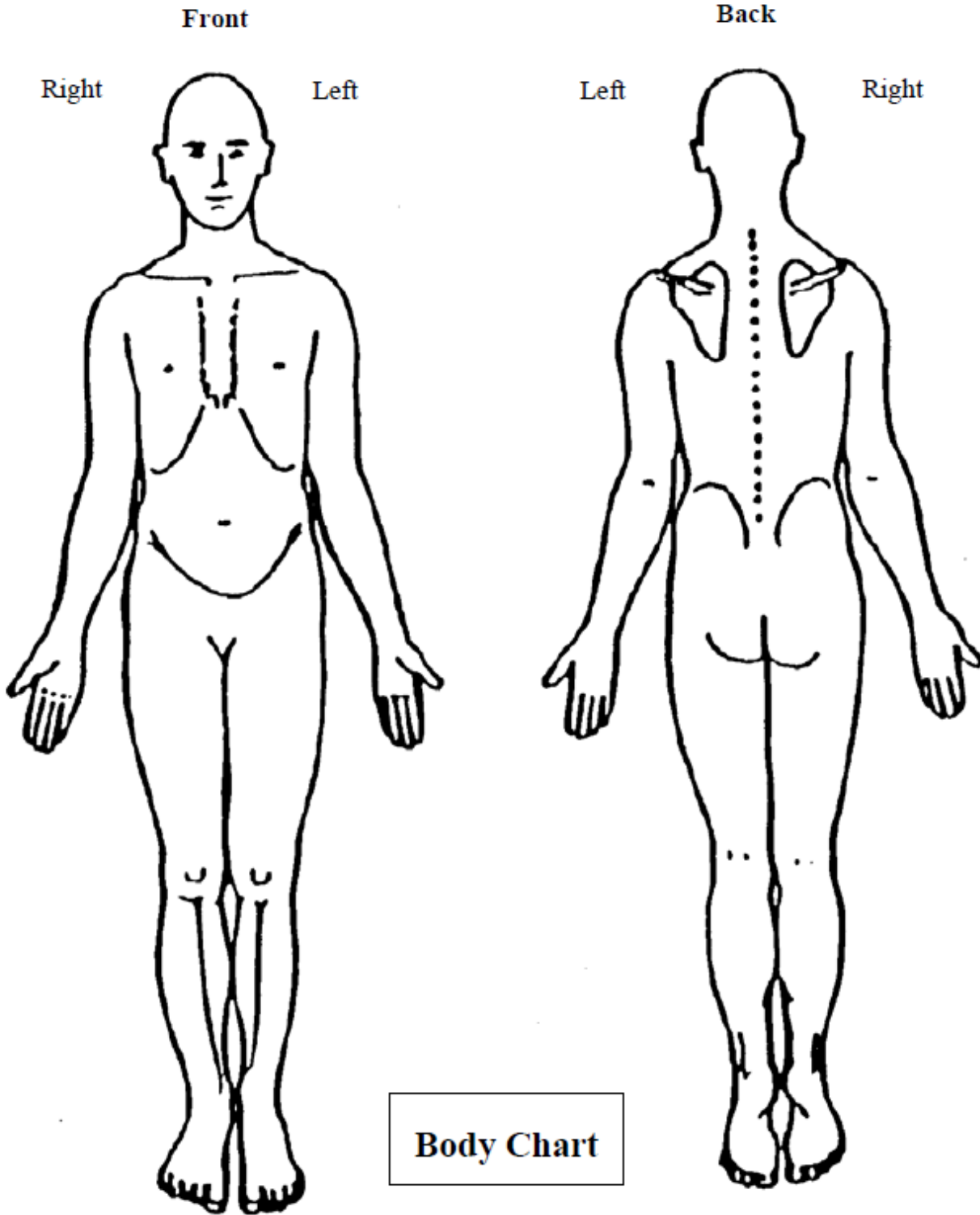
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(Taken from Healthy Dancer Canada Pre-professional Dancer Screening Tool – 2016)



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23. On the body chart, SHADE IN each of the areas where you experience **pain/problems**.
 Put an **X** on the **ONE** area that HURTS the most.





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DASS21

Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

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Your Health and Well-Being

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Thank you for completing this survey!

For each of the following questions, please mark an in the one box that best describes your answer.

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
▼	▼	▼	▼	▼
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

Yes, limited a lot	Yes, limited a little	No, not limited at all
▼	▼	▼

- a Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf..... 1..... 2..... 3
- b Climbing several flights of stairs 1..... 2..... 3

3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
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- a Accomplished less than you would like 1..... 2..... 3..... 4..... 5
- b Were limited in the kind of work or other activities 1..... 2..... 3..... 4..... 5

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4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
▼	▼	▼	▼	▼

- a. Accomplished less than you would like 1 2 3 4 5
- b. Did work or other activities less carefully than usual..... 1 2 3 4 5

5. During the past 4 weeks, how much did the pain interfere with your work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
▼	▼	▼	▼	▼
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

All of the time	Most of the time	Some of the time	A little of the time	None of the time
▼	▼	▼	▼	▼

- a. Have you felt calm and peaceful?..... 1 2 3 4 5
- b. Did you have a lot of energy?..... 1 2 3 4 5
- c. Have you felt downhearted and depressed?..... 1 2 3 4 5

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7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with your friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
▼	▼	▼	▼	▼
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Thank you for completing these questions!

Hays, RD (1994). The Medical Outcomes Study (MOS) Measures of Patient Adherence. Retrieved June 6, 2017, from the RAND Corporation web site:
<http://www.rand.org/health/surveys/MOS.adherence.measures.pdf>.