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Confidential Client Information Today's Date _____

Name _____ Phone: _____

Address _____

City, State & Zip _____ Date of Birth: _____

Email: _____ Occupation:_____

Height: _____ Weight: _____ Referred by _____

Recreational Activities / Hobbies _____

What is your primary area of complaint? _____

How did this condition develop? _____

Does it interfere with your work? _____ sleep? _____ daily routine? _____

What makes it better? _____ worse? _____

Do you have any other areas of discomfort? _____

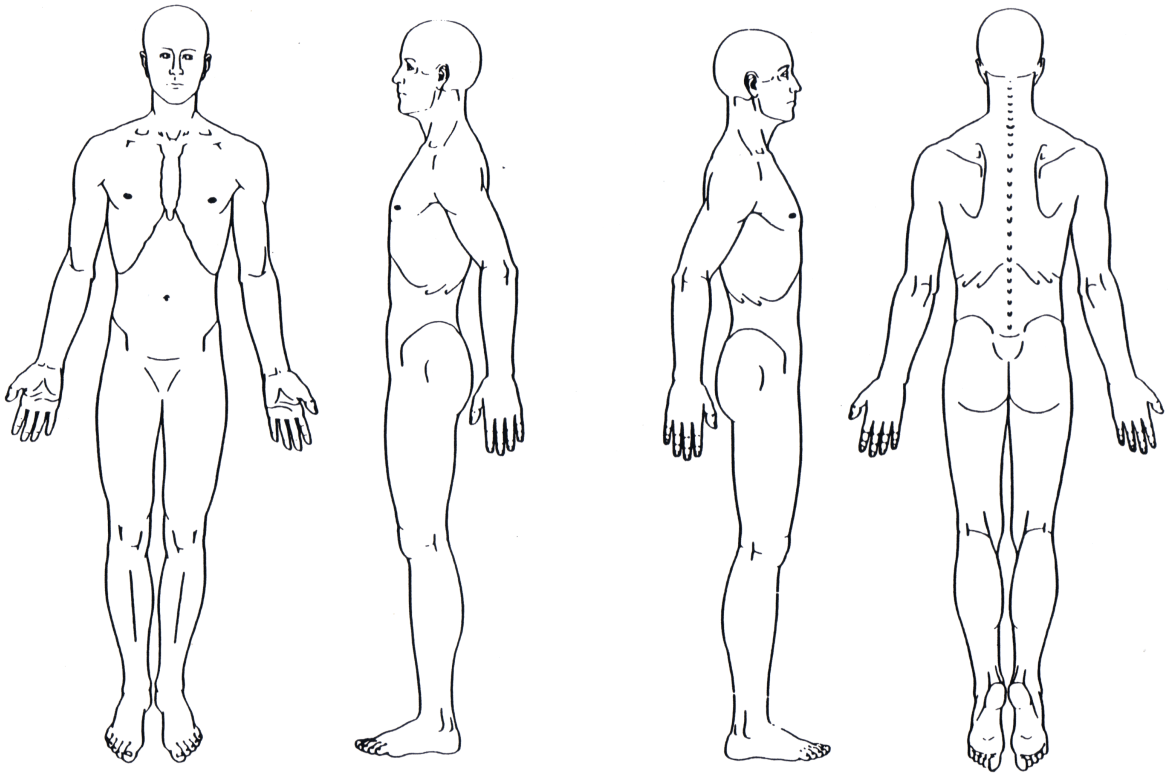
Using the provided key, please mark the body chart below.

O Circle areas where you are experiencing **PAIN**

Squiggly Line areas of **NUMBNESS** OR **TINGLING**

Asterisk areas of **JOINT** & **MUSCLE STIFFNESS**

Mark **SCARS**, **BRUISES**, or **OPEN WOUNDS**



How would you describe your general health? _____

Describe your physical activities at work/home/etc _____

_____

How much of these items do you consume daily?

Water _____ Alcohol _____ Coffee/Soda _____ Cigarettes _____

Rate your stress level: Low _____ Moderate _____ High _____

How do you relax? _____

Is there anything about you or your health that you would like to change? If so, what? _____

_____

Are you currently under the care of a medical doctor, chiropractor, naturopath, or therapist? _____

Current Condition(s) Treated _____

_____

Please list any hospitalizations/major injuries & dates _____

_____

Please list any current over the counter or prescription medications & reason for use _____

_____

_____

Please check any conditions that apply to you.

- ❑ Headaches
- ❑ TMJ Disorder
- ❑ Hearing Problems
- ❑ Sinus Problems
- ❑ Asthma
- ❑ Shortness of Breath
- ❑ Emphysema
- ❑ High or Low B/P
- ❑ Heart Disorder
- ❑ Varicose Veins
- ❑ Heart Attack
- ❑ Stroke
- ❑ Pacemaker
- ❑ Heartburn
- ❑ Diabetes
- ❑ Gout
- ❑ Arthritis
- ❑ Fibromyalgia
- ❑ Epilepsy
- ❑ Cancer
- ❑ Psoriasis / Rashes
- ❑ Cold Sores
- ❑ Hepatitis
- ❑ HIV / AIDS
- ❑ Phlebitis/Blood Clots
- ❑ Hemophilia
- ❑ Physical/Sexual Abuse
- ❑ Dizziness / Vertigo
- ❑ Food or Nut Allergies - Describe:_____
- ❑ Muscle Cramps
- ❑ Chronic Fatigue Syndrome
- ❑ Pins/Wires or Artificial Joints
- ❑ Tingling, Burning or Loss of Sensation anywhere

For Women

- ❑ PMS / Painful Menstruation
- ❑ Cervical Dysplasia
- ❑ Menopause Complications
- ❑ Other Gynecological Condition

Describe:_____

- ❑ Are you Pregnant? How many weeks:_____
- ❑ Previous Pregnancies # of Children_____

Other: _____