

NEW CLIENT FORM

Date

Name

Phone

DOB

Email

Address

City/State/ZIP

Emergency Contact (name/number)

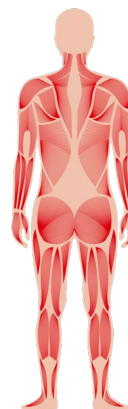
Referred By

GENERAL INFORMATION

What is your main reason for coming to therapy?

What specific goals would you like to achieve from therapy?

Where are your symptoms located?
Please mark the area on the figure



How long have you had these symptoms? Are you currently or have you ever been under medical supervsions for this problem?

Have you had any tests for the his problem?

X-rays

MRI

CT Scan

None

Describe the symptoms. Please check all that apply:

Dull	Burning	Periodic	Sore	Numb
Ache	Sharp	Constant	Stiff	Tingling

What makes it better or worse?

On a scale of 1-10, with 10 being the most severe discomfort, what is your discomfort level right now?

What time of day is the pain worse?

PHYSICAL FACTORS

What physical activities are you currently involved in?

Do you stretch now?	yes	no	Do you feel flexibility is an important part of fitness?	yes	no
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Have you ever had chiropractic treatment? If yes, how long, often, and with whom?

Have you ever seen a Naturopathic doctor?	yes	no	Do you wear any type of supportive braces anywhere?	yes	no
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Have you experienced any kind of bodywork before (i.e. massage, acupuncture, etc.)? If so, what?

Do you wear orthotics?	yes, For this many years:	no	Are your symptoms worse at the end of the workday?	yes	no
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What percentage of your day is spent sitting, standing, and/or driving?

Does your work station give you support and encourage good posture?	yes	no	How would you rate your own posture?
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MEDICAL HISTORY

Please list any recent injuries, illnesses, or surgeries:

Are you currently under the care of a physician? If yes, Explain:



MEDICAL HISTORY CONT.

Cancer	Asthma	Immovable Joints
Digestion problems	Hi/Low Blood Pressure	Epilepsy
Migrains/ headaches	Elimination Problems	Ulcers
Back Problems	Respritory Problems	Cold Hands/Feet
Sciatica	Sinus Problems	Heart Problems
Stroke	Arthritis/Bursitis	Bruise Easily
Scoliosis	Immune Disorder	Allergies
Osteoporosis	TMJ	Fibromyalgia
Diabetes	Tendonitis	Carpal Tunnel

List any current medications including aspirin, ibuprofen, etc.

Do you have any chronic or frequent pain?	yes	no	Have you had any accidents, auto or other?	yes	no
Do you have any chronic or frequent pain?	no	Yes. Check all symptoms that apply	dizziness	visions change	hearing change

Are there any other medical condition the therapist should be aware of?

Are you pregnant no yes How many weeks if so:

The above information i accurate and true to the best of my knowledge. If there are any chages in my current level of health, I will inform the person that I am seeing of my condition. I understand that the office does not idagnose or treat illness or diseases and does not prescribe medications. I agree to pay my account with the office in accordance with the regular rates and payment terms. If, for any reason, cancellation is necessary, I will give a 24 hour notice. I understand that if I do not give this notice, I will be charged for the appointment unless it can be filled. Owner will determine emergency cancellations. Its is agreed that any claim of liability is herby waived.

Sign _____

Date

