Client History

Name: ______________________ **Date of 1st visit:** __________

Address: _____________________ **Age:** _____

____________________________ **Occupation(s):** ________________

Phone #: _____________ **E-mail:** _______________________

How were you referred to me? Family,friend, another practitioner, Yelp, etc.

- ◻ ____

What are you hoping to get out of this session or series of sessions?

- ◻ ____
- ◻ ____

What therapies have you used to remedy this/these issues?

Chiropractic: ________________
Physical Therapy: ________________
Acupuncture: ________________
Massage: ________________
Other: ________________

Do you take any medications for pain management? ______________________
AND
How frequently? __________

Please ☑ and briefly explain on the back of this sheet any of these conditions that apply to you:

- ◻ **Scoliosis**
- ◻ **Gastro-intestinal disorder**
- ◻ **Heart condition**
- ◻ **Arthritis**
- ◻ **Vertigo**
- ◻ **High or Low blood pressure**
- ◻ **Incontinence**
- ◻ **Migraine/Frequent headaches**
- ◻ **Disc herniations/degenerations**
- ◻ **Osteopenia/Osteoporosis**
- ◻ **Allergies**
- ◻ **Blood clots**
- ◻ **Pregnancies**
- ◻ **Frequent muscle cramping**

Surgeries & when?: __________________________________

Broken bones & when?: ____

What sorts of things do you like to do for exercise? _____________________
AND
How many hours per week do you spend exercising?___________