Client Name:______________________________ **email:**________________________

Address:__________________________ **City, State:**________________ **Zip:**_______

Home Phone:________________ **Mobile Phone:**______________ **Work Phone:**_______________

Date of Birth:_________ **Emergency Contact:**____________________ **Phone:**_______

How have you been feeling lately –both physically and emotionally?

____

Do you suffer from any illnesses or medical conditions of the following systems?

☐ **Nervous** ________________________ ☐ **Musculoskeletal** ________________________

☐ **Cardiovascular**__________________ ☐ **Respiratory** __________________________

☐ **Digestive**_________________________ ☐ **Urinary** ______________________

☐ **Endocrine**_________________________

Are any of the conditions cancerous? ______________________________________

Have you been involved an auto accident or other personal injury in the last year?________

Have you had any surgeries in the last 10 years?_______ **If yes, for what?**____________________

____

Do you have any allergies?___________ **If yes, what are the allergies and how severe are your reactions?**____

____

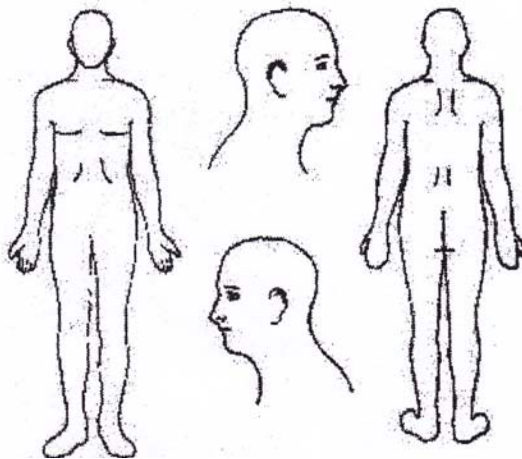
____

Are you currently taking any prescribed medications or drugs?_____**If yes, please list them and give the reason for taking them:**____

____

____

On the images below, please mark the areas that are problematic for you and then indicate next to each mark how bad the tension or pain is on a scale of 1 to 10 (1 being almost no discomfort, 10 being severe discomfort):



Do you suffer from or have any issues of the following:

☐ **Depression** ____________________ ☐ **Anxiety** ______________________________

☐ **Weight Control**_________________ ☐ **Fibromyalgia** _____________________

☐ **Sleep Loss**_____________________ ☐ **Substance Abuse** _________________

☐ **Addiction(s)**____________________________ ☐ **Eating Disorder(s)**____________________

☐ **Physical/Emotional Abuse**____

Physical Activity:

Do you consider yourself an active individual? Yes / No / Not as active as I'd like

What activities do you participate in? ____

____

What are your physical goals? ____

____

What restrictions do you feel are keeping you from those goals? __________________________________

____

On a scale of 1 to 10 (1 being not at all, 10 being extremely) how motivated are you to overcoming your physical restrictions and achieving your goals? 1 2 3 4 5 6 7 8 9 10

For female clients:

Are you pregnant?___ If yes, how many months along are you?_

Do you suffer from any secondary problems do to or in conjunction with your menstrual cycle?

________________ **If yes, what are those issues?**____

____

Are you currently on any hormone replacement therapy?_________

How did you hear about us?

(and please give names, we would like to thank them)

☐ **Friend/Family:** _________________________

☐ **Doctor:**_________________________________

☐ **Web Site:**_______________________________

☐ **Event:**_________________________

☐ **Organization/Group Member:**_____________________________________

☐ **Other:**_________________________________

Therapist's Notes:____

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