Client History Form

Name:_____ Sex:_____ Date of Birth_____

Address:_____City:_____ State:_____ Zip:_____

Phone: hm_____ wk_____cell:_____

E-mail:_____

Occupation:_____

School or Hours worked/week:_____ Do you sit for long periods on the computer?_____

Do you travel for school? sports? work?_____If yes, how often?_____

Fitness Goal(s):_____

Date of last physical:_____

Are you currently under a physician's care?_____If yes, what for?_____

Physician's Name:_____Phone number:_____

Please complete all of the following, use the back-side if you need additional space.
If you answer yes to any of these questions, please explain

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Client History Form

Have you ever experienced: (explain)

High Blood Pressure __YES __NO _____
Heart Trouble __YES __NO _____
Circulation Trouble __YES __NO _____
Seizures __YES __NO _____
Dizzy Spells __YES __NO _____
Diabetes __YES __NO _____
Other Illness __YES __NO _____
Cancer __YES __NO _____

Have you ever had surgery? __YES __NO _____
If yes, please list date, type of procedure, and outcome:
Type of Surgery_____Date_____Outcome_____

Type of Surgery_____Date_____Outcome_____

Have you ever been in an accident? ___YES ___NO
Explain:_____
_____
_____

Do you have any metal anywhere in your body (other than teeth)? __YES __ NO

Do you have a cardiac (heart) condition? __YES __NO _____
Do you have any trouble with vision? __YES __NO_____
Do you have any trouble with hearing? __YES __NO _____
Are you pregnant? __YES __NO
Do you have any allergies? __YES __NO
Please list: _____

List any medications/Supplements you are currently taking and why:

Medication:_____Reason:_____Dose:_____
Medication:_____Reason:_____Dose:_____
Medication:_____Reason:_____Dose:_____
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Medication:_____Reason:_____Dose:_____
Medication:_____Reason:_____Dose:_____
Medication:_____Reason:_____Dose:_____

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Have you ever had any physical therapy treatment? __YES __NO
Physical Therapist Name:_____Phone:_____

If yes please explain: _____
_____
_____
_____
_____

Present injury(s):_____
_____
_____
Dates of injury:_____
_____

Have you ever seen a chiropractor? __YES __NO
Chiropractor Name:_____Phone:_____
If yes, please explain:
_____
_____
_____
_____

Were you diagnosed with any of the following:

Atlas Subluxation	____YES ____NO
Stenosis	____YES ____NO
Spondyloyosis	____YES ____NO
Spondylolisthesis	____YES ____NO
Herniated disc	____YES ____NO
Bulging disc	____YES ____NO
Sciatica	____YES ____NO

Please bring any x-rays evaluations to appointment.

Do you smoke?_____If yes, how much:_____

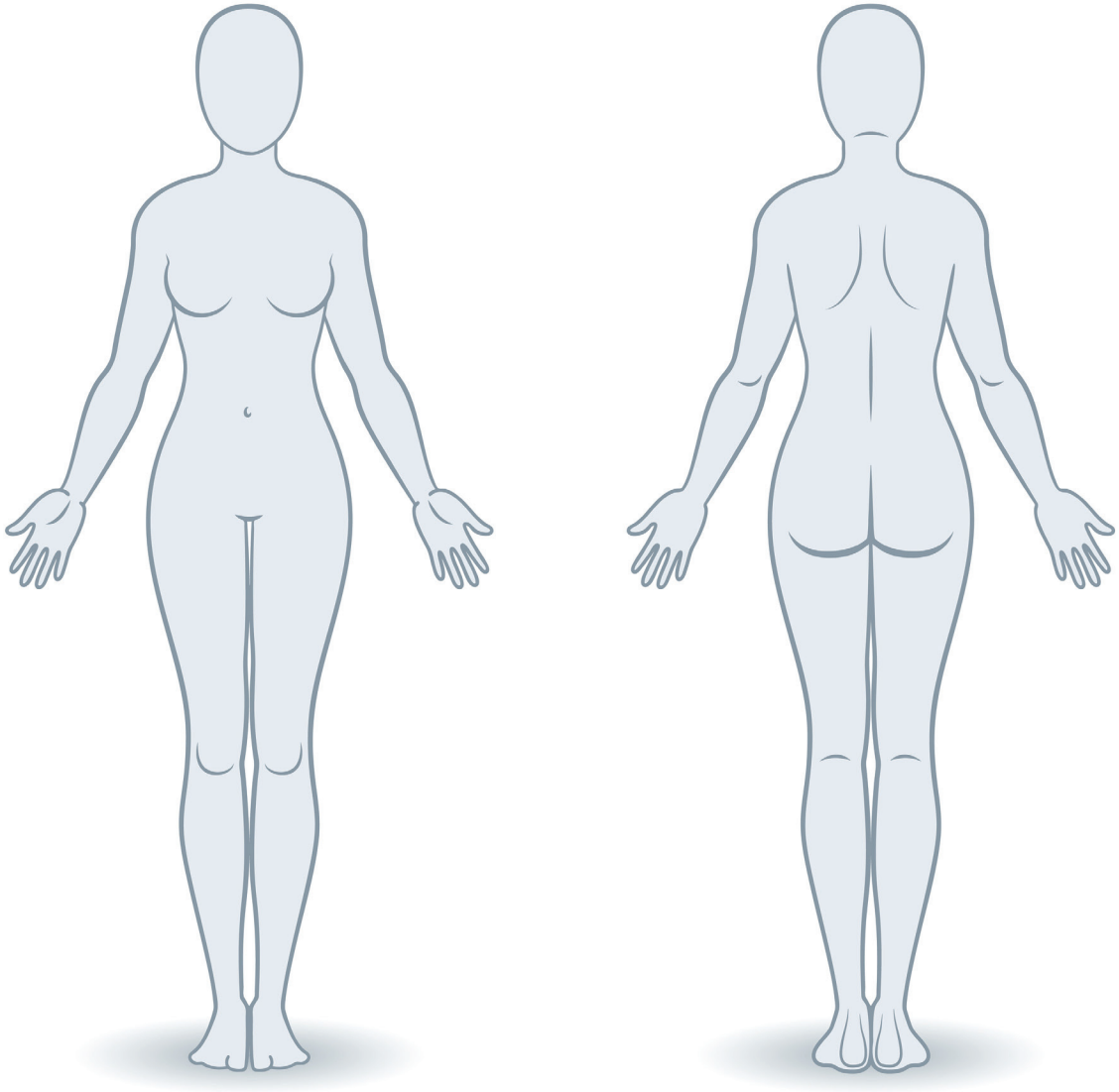
I understand that payment is expected at completion of each session.

Name: Print_____

Signature_____Date:_____

Client History Form

Please indicate where you have the following symptoms with the appropriate symbol
Pain = shaded area Numbness = X Tingling = Dots Swelling = O Spasms = #



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How long have symptoms been present? _____
_____

Improving / Unchanging / Worsening? _____

Commences as a result of: _____
_____
_____
_____

Symptoms: Constant or Intermittent

Worse when:
__sitting __turning __lying/rising
__am ___as day progresses __pm
__stationary ___on the move

Better when:
___sitting ___turning ___lying/rising
___am ___as day progresses ___pm
___stationary ___on the move

Do symptoms disturb your sleep? _____
_____

In which position do you sleep in? ___ back / ____side / ___belly

Does it hurt to cough, sneeze, or swallow? _____
_____

Previous Treatment? _____
_____

Medications:_____

Any significant weight loss recently: _____