Client Health Information Sheet

Name: ______________________________ Date: ____________

Who referred you to this office? Name: ______________________________

❑ Yellow Pages ❑ Advertisement ❑ Sign ❑ Other: ____________

Present symptoms: What is your major complaint or condition you want to improve? ____________

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When did you first notice major complaints? ______________________________

What brought it on? ______________________________

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What activities aggravate the condition? ______________________________

____

Is this condition getting progressively worse? ❑ Yes ❑ No

Please Explain: ______________________________

____

Does this condition interfere with work? ❑ Y ❑ N Sleep? ❑ Y ❑ N Daily Routine? ❑ Y ❑ N

Please Explain: ______________________________

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What have you done to get relief? ______________________________

____

Has there been a medical diagnosis? ❑ Yes ❑ No

If so, by whom? ______________________________

Please Explain: ______________________________

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Have you had X-rays taken? ❑ Yes ❑ No

If yes, by whom? ______________________________

What are your intentions or expectations for this visit? ______________________________

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Are you now under medical/therapeutic treatment? ❑ Yes ❑ No

If yes, for what condition? ______________________________

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Please list your care provider's name and phone number: ______________________________

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List any medications (including aspirin) and nutritional supplements you are taking: ___________

____

Describe the exercise activities you do (include frequency): ______________________________

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List other therapies you receive: ______________________________

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Please list (date and description) any accidents or operations: ______________________________

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Please list any additional comments regarding your health and well-being: ______________________________

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