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?_____

_____

When did you first notice major complaints?_____

What brought it on?_____

_____

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: _____

_____

What have you done to get relief?_____

_____

Has there been a medical diagnosis? ❑ Yes ❑ No

If so, by whom? _____

Please Explain: _____

_____

Have you had X-rays taken? ❑ Yes ❑ No

If yes, by whom? _____

What are your intentions or expectations for this visit? _____

_____

_____

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

If yes, for what condition? _____

_____

_____

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

_____

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

_____

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

_____

List other therapies you receive: _____

_____

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

_____

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

_____

_____

_____

_____