Client Information:

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:

Emergency Contact Information

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, contact: Phone number:

Reason for coming:

Onset Date:\_\_\_\_\_\_\_\_\_

Have you received other treatment for this problem? Results?

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Referral source?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunization status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| ✓ |  | Explain |
|  | Arthritis |  |
|  | Asthma |  |
|  | Bowel or Bladder Problems |  |
|  | Cancer |  |
|  | Coronary Artery Disease |  |
|  | Diabetes |  |
|  | Diverticulitis |  |
|  | Endometriosis |  |
|  | Fibroids |  |
|  | Fractures |  |
|  | Frequent Falls |  |
|  | Heart Disease |  |
|  | Migraine Headaches |  |
|  | Osteoporosis |  |
|  | Seizures |  |
|  | Other |  |

**List all Chest/Abdominal Surgeries**

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|  |
|  |

**Traumatic Injury/MVA**

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|  |
|  |