

Client Questionnaire

Name: _____

Date: _____

Age: _____

Sex: _____

Phone: _____

Email: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Phone: _____

- 1).** Please take a moment to describe the pain, sensation, or condition that has brought you here, including details about any accident or injury if applicable.

- 2).** Please use a check mark to indicate if any of the following do or have applied to you. Please indicate all that apply to you.

- | | |
|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Heart or circulation disorders | <input type="checkbox"/> Epilepsy / seizure disorder |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer / Tumors |
| <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Degenerative Joint Disease | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Arthritis / Osteoarthritis | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Recent infections |
| <input type="checkbox"/> Kyphosis | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Smoking habit |
| <input type="checkbox"/> Auto Immune Deficiency | <input type="checkbox"/> Back or Neck Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Car Accidents / Whiplash |
| <input type="checkbox"/> Direct injuries / trauma to head or neck | <input type="checkbox"/> Sleep Apnea or disturbances |
| <input type="checkbox"/> Joint swelling / stiffness | <input type="checkbox"/> Other _____ |

3). Please list any surgeries and elective surgeries that you have undergone, including dates, if possible.

4). If you have been diagnosed with any diseases, please list them below.

5). Please list any medications or dietary supplements that you are currently taking.

6). Have you ever received cortisone or steroid injections? If so, please describe the number you've had, where they were administered and why they were administered.

7). Please briefly describe your typical work day.

8). Please indicate your level of stress in the following areas using "1" to represent very low stress and "10" to represent very high stress.

Employment:

Personal:

Relationships:

9). Please use the lines below to detail your exercise history.

• _____	<input type="text"/>	<input type="text"/>	<input type="text"/>
• _____	<input type="text"/>	<input type="text"/>	<input type="text"/>
• _____	<input type="text"/>	<input type="text"/>	<input type="text"/>
• _____	<input type="text"/>	<input type="text"/>	<input type="text"/>
• _____	<input type="text"/>	<input type="text"/>	<input type="text"/>

10). Please detail any forms of body-work that you receive, such as acupuncture, massage, chiropractics, etc.

11). Now, please focus on reviewing any pain, limitations of movement, or other specific conditions pertaining to the following areas of your body:

Feet

- Are they often painful? _____
- Can you walk barefoot? _____
- Do you have bunions or neuromas? _____
- Do you wear orthotics or inserts? _____
- Other condition? _____
- Additional description of any conditions:

Ankles, Knees & Hips

- Do you ankle pain or injuries? _____
- Do you have knee pain or injuries? _____
- Do you have hip pain or injuries? _____
- Other condition? _____
- Additional description of any conditions:

Back & Shoulders

- Do you have lower back pain or injuries? _____
- Do you have upper back pain or injuries? _____
- Do you have shoulder pain or injuries? _____
- Other condition? _____
- Additional description of any conditions:

Arms, Wrists & Hands

- Do you elbow pain or injuries? _____
- Do you have wrist pain or injuries? _____
- Do you have hand pain or injuries? _____
- Other condition? _____
- Additional description of any conditions:

Head, Neck & Shoulders

- Do you have neck pain? _____
- Do you have headaches? _____
- Do you have TMJ? _____
- Do you have shoulder pain? _____
- Other condition? _____
- Additional description of any conditions:

12). If there is any additional information that you would like to include, please use the space below to complete the questionnaire.