CLIENT HISTORY

GENERAL INFORMATION

Please check and fill in all applicable items.

Name: Last _____ First _____ Age _____ DOB _____ M___F___
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work or cell phone _____
Found out about us: ___ phone book ___ sign ___ web Referred by _____
Occupation _____ Employer _____
Emergency Contact _____ Phone _____

For office only

Client # _____
Date _____
DOE _____
DOI _____
Referral ___Y___N
Prior Client ___Y___N

Email _____ Automatic notices will be sent for *appointment reminders*.

CURRENT COMPLAINTS

1. _____ How long? _____ Getting: ____ Worse ____ Better Prior History ____ Y ____ N
2. _____ How long? _____ Getting: ____ Worse ____ Better Prior History ____ Y ____ N
3. _____ How long? _____ Getting: ____ Worse ____ Better Prior History ____ Y ____ N
4. _____ How long? _____ Getting: ____ Worse ____ Better Prior History ____ Y ____ N

Are your current complaints due to an injury? ____ Y ____ N ____ Auto ____ Work ____ Sports ____ Other _____
Has an accident been reported? ____ Y ____ N Have you retained an attorney? ____ Y ____ N Name _____

Do you have any of the following today? (please check/fill in)

_____ Cold or Flu _____ Inflamation/Swelling _____ _____ Poison Ivy/Oak _____
_____ Temperature _____ Cuts/Bruises _____ _____ Burns _____
_____ Headache _____ Skin Rash _____ Sensitivity to
_____ Sunburn _____ Other _____ _____ Heat _____ Cold _____ Aroma

PRIOR TREATMENT

Have you been treated for above complaints by any of the following? (please check/fill in)

____ Chiropractor ____ Physical Therapist ____ Naturopath ____ Osteopath ____ MD ____ Acupuncturist

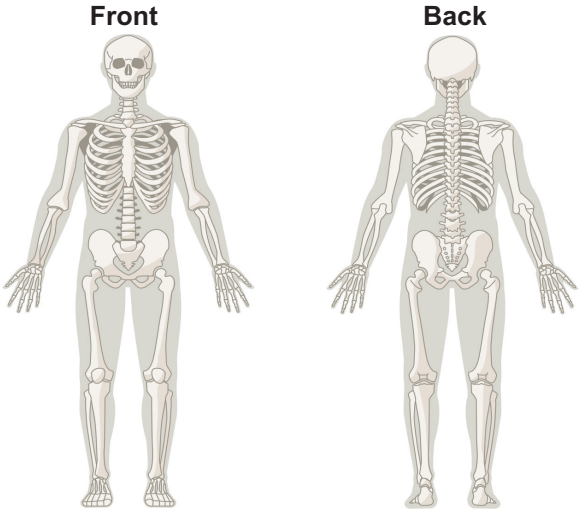
Name of treating provider _____ When? _____
Results of Treatment _____
Have you ever received Massage Therapy? ____ Y ____ N Name _____ When? _____

SUBJECTIVE STATUS

Primary (#1) complaint severity scale

less 0 1 2 3 4 5 6 7 8 9 10 more

P = Pain
A = Ache
S = Stiff
B = Burn
Sh = Shooting
Sp = Spasm
N = Numb
T = Tingling



Staff of Therapist's Notes Only

_____
_____
_____
_____
_____
_____

Staff

Therapist's Notes Only

_____
_____
_____
_____
_____
_____

Therapist

Please complete the following before care is considered
Circle all current conditions AND all recurrent conditions AND all previously diagnosed conditions rendered from a health care provider.

Client only	Notes	Client only	Notes	Client only	Notes	Client only	Notes
Allergies		Shoulder pain		Asthma		Spitting blood	
Chills		Elbow/wrist pain		Emphysema		Blood in urine	
Convulsions		Knee/foot pain		Deafness		Blood in stool	
Dizziness		Swollen joints		Ear noises		Frequent urination	
Fainting		Belching or gas		Thyroid disease		Difficulty holding urine	
Fatigue		Indigestion		Hoarseness		Painful urination	
Headache		Acid reflux		Bleeding		Prostate disease	
Loss of sleep		Irritable bowel		Easy bruising		Painful periods	
Weight gain		Diarrhea		Ear pain		Breast implants	
Nervousness		Excess hunger		Chest pain		Pregnancy	
Nerve pain		Jaundice		High blood pressure		Seizures	
Night sweats		Hepatitis		Low blood pressure		Depression	
Numbness		Liver disease		Heart pain		Anxiety	
Recur. twitches		Gall Bladder		Heart disease		Cancer	
Tremors		Aids		Stroke		Diabetes	
Difficult breathing		Pancreatic disease		Ankle swelling		Contagious disease	
Neck pain		Kidney disease		Feet swelling		Lupus	
Thoracic pain		Nausea		Varicose veins		Multiple Sclerosis	
Low back pain		Abdominal pain		Skin disease		Head injury	

OTHER HEALTH INFORMATION

Surgeries Initial here _____ if you have NEVER had any surgeries.

List all surgeries	Date	List all surgeries	Date

Injuries Initial here _____ if you have NEVER had any injuries.

List all accidents resulting in treatable injuries. Include auto and spinal injuries. List all dates

Spinal History Initial here _____ if you have NEVER had any non-surgical spinal procedures.

List all non-surgical procedures including spinal taps, injections, braces, etc. List all dates

List of all Medications and Nutritionals Initial here _____ if you DO NOT take medications, supplements or herbs.

List all non-surgical procedures including spinal taps, injections, braces, etc.

Please list all disease (diabetes, lupus, liver, kidney, cancer, etc.) for

Yourself _____

Your immediate family _____

Do you Smoke? ____ Y ____ N ____ per day Drink Alcohol? ____ Y ____ N ____ per day Exercise? ____ Y ____N ____ per week

Do you have any history of cancer? ____ Y ____ N If yes, what type and when? _____

Statement of Accuracy and Consent to Treat

By signing below, I agree that I have completed the above form and I have not omitted, nor misrepresented any requested health information and that as with all health care protocols, there is an inherent risk of post treatment soreness and/or aggravation of known pre-existing conditions. I further understand that the inherent risks noted above are substantially less thank the adverse effects of NSAIDS and various other medications for the control of muscular skeletal dysfunction. I fully understand the above and give my full consent for assessment and treatment according to the standards and practices of soft tissue therapy.

Signature of client or guardian _____ **Date** _____