Client Information Form

Name:_____ Email Address: _____ Date:_____
Address: _____ City/State: _____ Zip: _____
Birthdate: _____ Occupation: _____ Driver's License #: _____
Home phone: _____ Work phone: _____ Cell phone: _____
Fax number: _____ What is the best way to reach you? _____
Spouse's employment: _____ Spouse's work phone # _____
Emergency contact's name and phone #: _____
How did you hear about our practice: _____

Please respond to each item below. Explain your affirmative answers in the comment section.

1. Medical treatment (presently)	( ) Yes ( ) No	14. Prior tests or treatment for your current condition	( ) Yes ( ) No
2. Heart Condition	( ) Yes ( ) No	15. Osteomyelitis	( ) Yes ( ) No
3. Thyroid problems	( ) Yes ( ) No	16. Major illness or injury	( ) Yes ( ) No
4. Cancer	( ) Yes ( ) No	17. Surgery	( ) Yes ( ) No
5. Diabetes	( ) Yes ( ) No	18. Medications in last 6 mths	( ) Yes ( ) No
6. Arthritis	( ) Yes ( ) No	19. Chronic body discomfort	( ) Yes ( ) No
7. Convulsions	( ) Yes ( ) No	20. Contact lenses	( ) Yes ( ) No
8. Phlebitis	( ) Yes ( ) No	21. Dentures/Bridge	( ) Yes ( ) No
9. High/Low blood pressure	( ) Yes ( ) No	22. IUD	( ) Yes ( ) No
10. Osteoporosis	( ) Yes ( ) No	23. Pregnancy/Childbirth	( ) Yes ( ) No
11. Hemophilia	( ) Yes ( ) No	24. Infectious conditions	( ) Yes ( ) No
12. HIV	( ) Yes ( ) No	25. Psychotherapy	( ) Yes ( ) No
13. Hepatitis	( ) Yes ( ) No	26. Other bodywork	( ) Yes ( ) No

Comments: (Please reference item numbers.)

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What are your treatment goals and objectives? (Please be specific):

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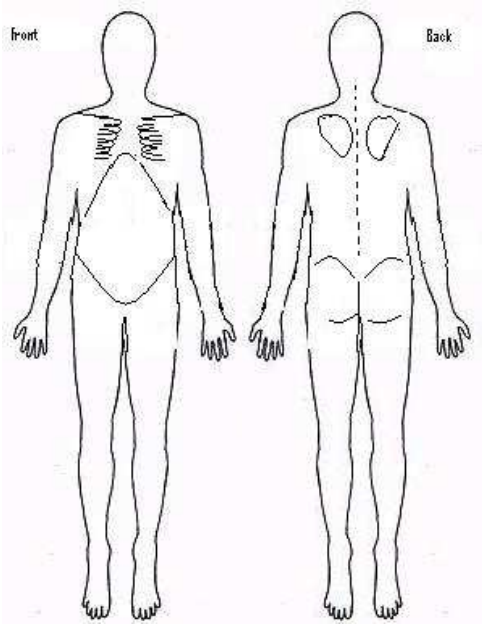
Please indicate painful areas
by shading these models:



1. Please rate the level of your pain on a scale of 1 to 10.

   1 2 3 4 5 6 7 8 9 10

   Mild Discomfort — Moderate Pain — Extreme Agony

2. Which of these words describe your pain?
   (check all that apply)
   ( ) Sharp ( ) Dull ( ) Burning
   ( ) Tingling ( ) Numb ( ) Constant
   ( ) Aching ( ) Variable

3. Is your condition due to an: A) Auto accident B) Work injury C) Other accident

   D) Unknown cause E) Illness F) Other: _____

4. When did your symptoms first begin (or accident occur)? _____

5. Have you had these symptoms before? _____ If so, when? _____

6. If you have pain, does it radiate (move), or is it localized to one area? (Describe) _____
   _____

7. How often does your pain occur? _____

8. Does anything (activity, therapy, etc.) help your pain? _____

9. Circle any activities which aggravate your condition: A) Standing B) Walking C) Sitting

   D) Lying E) Bending F) Lifting G) Twisting H) Coughing I) Other: _____

10. Are your symptoms: A) Improving B) Getting worse C) Constant D) Intermittent E) Other:
    _____

11. Do you exercise regularly? _____
    What exercise? _____
    How often and how long? _____
    Do you consume alcohol? (How much?) _____
    Do you consume caffeine? (How much?) _____