CLIENT EVALUATION FORM
& MEDICAL HISTORY

Patient Name: _____ Date: _____

Address: _____ Phone: _____

City: _____ State: _____ ZIP: _____

Emergency#_____ Date of Birth: _____

Email: _____

We respect your privacy and will only use these addresses for clinic news and information.

Primary concern:

What are your symptoms?

When did your symptoms begin?

How did your symptoms occur?

Any surgeries? Yes No

Type and Date of surgery:

Do you have any scars on your body and where?

Are you pregnant? Yes No

Pain Level (0/10 = no pain, 10/10 is worst pain imaginable):

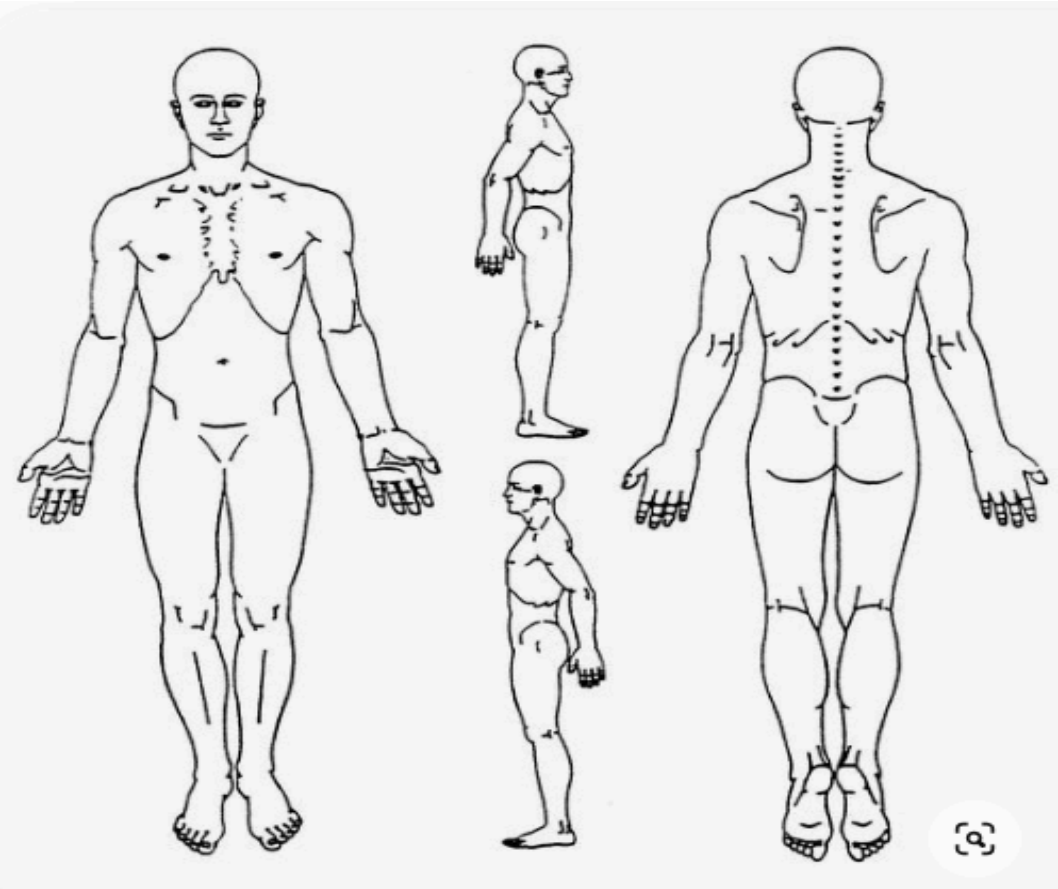
Where is the pain located?

Current pain level?

Best in last 2 weeks?

Worst in last 2 weeks?

IMPORTANT: Please Shade Areas of Pain or Discomfort Below:



Blood Pressure: High Low Normal

Digestion: Regular Irregular: Too slow Too fast

Food sensitivities or modification:

Prescriptions or herbs:

Menstruation: Regular Irregular Painful Strong Weak

Sleep: Hours per night: Wake: Bedtime:

Current forms of exercise:

What are you unable to do as a result? Why?

Why do you want/or need to be able to do this?

What interventions and treatments have you tried?

What are the meaningful activities or events that you are missing out on due to this?

What would you like to accomplish or see happen?

How long do you think it should take to reach your goal? Why?

What would get in the way of you completing or continuing, or starting treatment? Why?

What is your belief level (1-100%) that you can get better /see improvements?

What helps?

What are you willing to do to reach your goal?