Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential.

Please print clearly in ink.

Name: ____________________ Sex: M / F Date:__________

Email:________________________

Address:___________________________ City:_____________ State:___

Zip:____________

Date of Birth ___________ Age _____

Telephone: Home ( ) ________________ Work ( ) ____________

Cell ( )________________ Emergency Contact:_______________________

Occupation:___________________________________

Referred by: ____

Reason for visit today:

____

Other problems

____

How long have you had this condition? ___________________

Have you ever experienced this before?____________________

What seemed to be the initial cause?

____

What seems to make it better?

____

What seems to make it worse?

____

Does it bother your : Sleep ____Work____ Other

(what?)____

Describe the exercise activities you do (include frequency):

____

____

List other therapies you receive:

____

____

MEDICINES:

Prescription drugs you are currently taking and for what condition?

____

____

____

____

____

____

____

____

Over-the-counter medication you are currently taking and for what condition?

____

____

____

____

____

____

MAJOR HOSPITALIZATIONS

If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

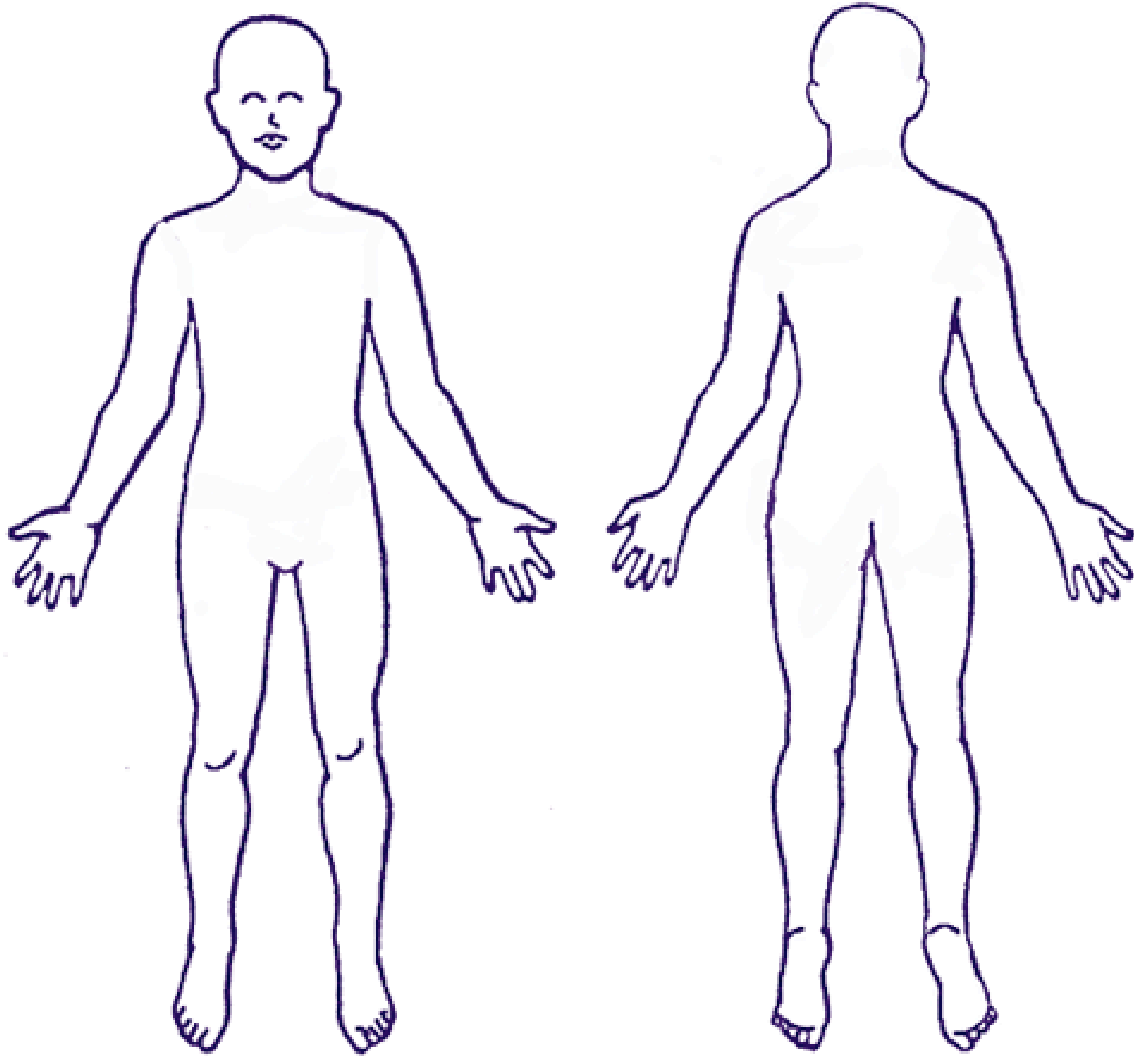
Year Operation/illness___________________________________

____

Have you ever had massage or bodywork before?   Yes   I   No

If so, Where? ____

Please Indicate with an **X** where on your body you feel discomfort and/or pain.



Thank you for your time.