

## Client Profile

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City Zip Code

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Type of work: \_\_\_\_\_

Sex: M/F Marital Status: \_\_\_\_\_ General Health:  Excellent  Good  Fair  Poor

Personal Goals: \_\_\_\_\_

Medications: \_\_\_\_\_

Previous Injuries: \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

Are you currently experiencing any physical problems? If so, please explain: \_\_\_\_\_

Are you currently receiving professional health care services? If so, please explain: \_\_\_\_\_

Date of last doctor's visit: \_\_\_\_\_ Do you smoke? Yes/No If Yes, how much? \_\_\_\_\_

Has your doctor indicated any limitation or exclusions of certain activities? Please describe: \_\_\_\_\_

Are you currently or have you been previously diagnosed with any of the following?

Arthritis	Yes	No		Herniated Disc	Yes	No
Back Pain	Yes	No		High Blood Pressure	Yes	No
Cancer	Yes	No		Hypoglycemia	Yes	No
Carpal Tunnel Syndrome	Yes	No		Numbness / Neck Pain	Yes	No
Circulatory Disease	Yes	No		Knee Pain	Yes	No
Diabetes	Yes	No		Osteoporosis	Yes	No
Dizziness	Yes	No		Pelvic Floor Pain / Weakness	Yes	No
Fainting	Yes	No		Pregnancy	Yes	No
Fibromyalgia	Yes	No		Seizure Disorder	Yes	No
Heart Disease	Yes	No		Shoulder impingement / pain	Yes	No
				Stenosis	Yes	No

Is there anything you feel we should know and have not asked? If so, please explain: \_\_\_\_\_

**I, THE UNDERSIGNED, DO HEREBY CERTIFY THAT I HAVE COMPLETED THE ABOVE INFORMATION AND KNOW IT TO BE TRUTHFUL AND ACCURATE TO THE BEST OF MY KNOWLEDGE.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_