CONFIDENTIAL CLIENT INFORMATION SHEET

Name:_____ **Date:**_____

Address: _____

Email Address: _____ **DOB:**_____

Phone Number: _____

Occupation: _____ **Employer:**_____

Personal Physician: _____ **Phone:** _____

Who can I thank for this referral? _____

Present Problems:	Level 1-10 (10 being take me to the doctor)	Date of Onset
1. _____	_____	_____-_____-_____
2. _____	_____	_____-_____-_____
3. _____	_____	_____-_____-_____

List 3 things you would like to be able to do after your sessions that you can't do now (i.e. golf, pick up grandchild, sit through a movie, etc.)

1._____ 2. _____ 3._____

Do you have any recommendations or restrictions from your physician? □ yes □ no

If yes, please explain: _____

Do you have a specific diagnosis from your physician? _____

Problems are getting: □ Better □ Worse □ Same

What makes you feel better? _____

What makes you feel worse? _____

What care are you currently under?

□ Acupuncturist
□ Chiropractor
□ Massage Therapist
□ Nutritionist
□ Personal Trainer
□ Physical Therapist
□ Physician
□ Other: _____

If employed, what are your current job activities?

□ Bending/Stooping
□ Driving/Traveling
□ Extensive phone time
□ Lifting
□ Prolonged Sitting
□ Prolonged Standing
□ Sitting at computer
□ Walking
□ Other: _____

Do you wear orthotics? □ yes □ no

Are you currently taking any medication? □ yes □ no
If yes, please list: _____

Do you currently smoke? □ yes □ no If yes, _____ packs a day

Do you have trouble sleeping due to pain? □ yes □ no

How many hours of sleep do you average each night? _____

What time of day do you have the most pain? _____

What kind of exercise or activities are you involved in? _____
_____

What is your primary reason for joining this program? _____

Do you have any home exercise equipment?

□ Balance Board
□ Stationary Bike
□ Tubing
□ Other: _____
□ Physioball
□ Treadmill
□ Weights

Past Medical History: Do you have a history of:

□ Arthritis
□ Balance Problems or Disturbances
□ Broken Bones
□ Burning or tingling in arms or legs
□ Cardiac Risk Factors
□ Childbirth
□ Natural □ C-section
□ Fibromyalgia
□ Gastrointestinal Issues
□ High Blood Pressure
□ Inner Ear Infections and /or Damage
□ Joint Replacement
□ Leg Length Discrepancy
□ Low Back Pain
□ Osteoporosis
□ Plantar Fasciitis
□ Sciatica
□ Scoliosis
□ Significant weight gain or loss in past year
□ Tendinitis
□ Visual Problems
□ Hip Dysplasia
□ Others: _____
_____

What past treatments have you tried to treat your pain? Did it help?

□ Acupuncture □ yes □ no
□ Chiropractic □ yes □ no

□ Exercise	□ yes □ no
□ Massage	□ yes □ no
□ Medication	□ yes □ no
□ Physical Therapy	□ yes □ no
□ Surgery	□ yes □ no
□ Other(s): _____	□ yes □ no

Surgeries: _____

Accidents/Injuries: _____

Short-Term Goal(s): _____

Long- Term Goal(s): _____

Time willing to invest in menu: _____

PLEASE READ AND SIGN:

I voluntarily authorize and give consent to Heather Browning to provide her services to me. This includes, but is not limited to, assessments, exercise prescription, and other corrective procedures.

I acknowledge that with any treatment there can be risks and I assume those risks. I further understand that no guarantees have been, or can be, made to me as to the result of the services provided by Heather Browning.

I understand that the services provided are not a substitute for medical examination or diagnosis, and it is recommended that a physician be consulted for that service.

I have informed Heather Browning of all my known physical limitations, medical conditions, and medications to the best of my knowledge, and I will keep her updated on any changes. I understand that there shall be no liability on Heather Browning's part due to my forgetting to relay any pertinent information.

I authorize the release of any information contained in my record for the following purposes:

a. Provide information to my health professional referral source,
b. Provide information to my personal physician

Prepayment of any package: I understand that after the completion of the 4th visit that there will be no refund of the remaining balance. However, Heather Browning, will honor any remaining visits for up to 6 months from the date of payment. Any unused portion after 6 months will not be refunded or honored. **Please Note:** Heather Browning requires a minimum of 24 hour notice for any cancelled appointment. I understand that a $25.00 fee will be charged to me for the first cancellation or no show that occurs with less than a 24 hour notice. I also understand that any future occurrences will be billed to me at the full cost of the appointment.

Client Signature: _____ Date: _____