New Client Questionnaire

Please offer thorough answers to the questions contained herein. Thank you!

Name: _____

Address: _____

Email: _____ Phone Number: _____

Gender: _____ DOB: _____ Age: _____

Emergency Contact Person: _____ Phone Number: _____

Relationship to You: _____ Their Email: _____

1. Briefly describe your present complaint(s) in order of priority:

_____
_____
_____
_____
_____
_____

2. What quantitative (e.g. run 5 miles pain free) and/or qualitative (e.g. wake up in the morning without pain) outcome(s) would you like from our work with together:

_____
_____
_____
_____
_____
_____

3. Describe your current or recent exercise history (past 6-12 months). What activities do you enjoy, or partake in regularly (or in the recent past)?

_____
_____
_____
_____
_____
_____

4. Circle your response; how would you rate your weekly stress level: low / medium / high

5. Do you have any lifestyle habits or obstacles that may make it difficult for your body to adapt to the changes that we are trying to make (staying up late, chain smoking, infrequent exercising, toxic relationships, addictions or bad habits)?

_____

_____

_____

6. Please list any diagnostic procedures you have had in the last 5-15 years (X-Ray, MRI, CT-Scan, etc.) below:

Diagnostic Procedure	Date	Physician

7. Please list all surgeries you have had at any time, ever.

Surgical Procedure	Date	Physician

8. Please list all medications (medically and self-prescribed) that you are currently taking - please indicate what they are for next to them in parentheses:

_____

_____

_____

_____

_____

_____

9. Have you ever had or do you currently have (cross off the following that apply to you):

High Blood Pressure	Fibromyalgia	High Cholesterol	Chronic Fatigue Syndrome	Heart or Circulation Disorders	Lupus
Family History of Heart Disease	Lyme Disease	Smoking History	HIV/AIDS	Asthma	Thyroid Condition
Cancer	Ulcerative colitis	SIBO, Crohn's Disease	IBS	Epilepsy or Seizure Disorder(s)	Rheumatoid Arthritis
Osteoarthritis	Urinary Incontinence	Scoliosis	Female Reproductive Issues	Spinal Fusions	Hernia
Joint Swelling or Stiffness	Whiplash	Osteoporosis	Migraines	Anxiety	Learning Disabilities or Cognitive Challenges
Food Allergies or Sensitivities	Pelvic Floor Issues	Fainting Spells	Vertigo	Depression	Concussions

10. Do you participate in any other healing or fitness modalities? If yes, please list name/practice & frequency of your visits per month:

Practice	Name of Practice / Specialist?	Frequency	Practice	Name of Practice / Specialist?	Frequency
Physical Therapy			Chiropractic Care		
Acupuncture			Massage		
Personal Training / Group Fitness			Active Release Techniques/ Rolfing		
Osteopathic Work			Pilates		
Yoga			Other		

11. Do you receive or have you had any cosmetic and/or plastic surgery (botox, tummy tucks, face lifts, breast implants, etc.)?

_____

_____

12. Do you wear glasses or contacts? Do you have astigmatism?

_____

13. Have you ever been in an automobile accident, motorcycle accident, bike accident, minor fender bender or major fall? Please list, share the date(s) and/or explain further:

_____

_____

_____

_____

_____

_____

14. What are you wearing on your feet? Please let me know below:

- Do you wear orthotics or insoles (past or present)?_____
- Do you wear flip-flops daily? _____
- Do you wear higher heeled shoes weekly (1 inch or higher)?_____

15. Please inform me about your sleep habits (write in or circle all that apply):

- How many hours do you sleep per night? _____
- Is it difficult to fall asleep? Yes / No
- When you wake you feel ready to tackle the day? Yes / No
- Do you often feel like you could sleep for 1-2 hours more? Yes / No
- Do you get up frequently at night, and/or toss and turn? Yes / No
- Do you snore or have sleep apnea? Yes / No

16. For Women, please fill out the below if it applies to you:

- Are you currently pregnant? If yes, how far along? _____
- Have you had any miscarriages or stillbirths?_____
- If you have children, how many & what are their ages?_____

  _____
- Were the births vaginal or cesarean? _____
- During birth, did you use medications such as an epidural or pitocin?

  _____
- Were there any complications during delivery or after delivery?

  _____