

New Client Questionnaire

Please take your time to fill out this form and 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):

2. What quantitative (run 5 miles) and/or qualitative (feel stronger) 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. 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, yo-yo exercising, addictions or inflammation)?

5. Please list any diagnostic procedures you have had recently (X-Ray, MRI, CT-Scan, etc.) below:

Diagnostic Procedure	Date	Physician

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

Surgical Procedure	Date	Physician

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

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

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

10. 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

11. 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:

12. Do you currently treat, manipulate or adjust yourself in any therapeutic ways? Please let me know.

13. 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 or on weekends? _____
- Do you wear higher heeled shoes weekly? _____

14. 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		

15. 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? _____
- 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?

16. Please inform me about your sleep habits:

- How many hours do you sleep per night? _____
- Is it difficult to fall asleep? _____
- Circle any of the below.
- When you wake you feel ready to tackle the day?
- Do you often feel like you could sleep 1-2 hours more no matter how much sleep you've gotten?
- Do you get up frequently at night, and/or toss and turn?

17. Would you rate your weekly stress level as low, medium, or high? _____

18. Let's discuss your work environment and habits, please circle the answer that applies:

- Is your work-station ergonomically correct Y / N
- Do you have a sit / stand desk? Y / N
- Do you use a headset when talking on the phone? Y / N