



CLIENT INFORMATION

Date: _____ Referred By: _____

Print Name: _____

Add Parent/Guardian Name if under 18 yrs of age: _____

Date of Birth: ____/____/____ Weight: _____lbs Sex: Male Female

Occupation: _____

Current Physician: _____

Medications you are currently taking/why: _____

Current Symptoms: _____

Regular Physical Activity/Sports: _____

History of Accidents or Injuries: _____

Emotional Trauma: _____

Surgeries: _____

Other: _____

By my signature I am stating that the above is true and accurate of my current physical and mental condition on this date, prior to services.

Signature: _____

(Add Parent/Guardian Signature if under 18 yrs of age): _____