CLIENT INFORMATION SHEET

NAME_____

ADDRESS _____

CITY/TOWN _____POSTAL CODE_____

PHONE (HOME)_____ (CELL / BUSINESS) _____

EMAIL ADDRESS (optional) _____

REFERRAL (if applicable) _____

Patient's main complaint_____

PRE-EXISTING CONDITIONS WE SHOULD KNOW ABOUT:

_____

_____

MEDICATION PRESENTLY BEING TAKEN:

_____

Please circle problem areas:

Arch	L	R	Low Back	L	R
Heel	L	R	Shoulders	L	R
Ankle	L	R	Neck	L	R
Achilles	L	R	Headaches	L	R
Bunions	L	R	DIABETES	yes	no
Knee	L	R	Numbness	yes	no
Hip	L	R	Tingling	yes	no

ARTHRITIS yes no (If yes, where_____ type_____)

ALLERGIES_____

SIGNATURE _____Date_____

*PATIENT IS A CHILD -- AGE*_____

SIGNATURE OF
*PARENT/GUARDIAN*_____