



COMPREHENSIVE CLIENT INFORMATION SHEET
Fascial Stretch Therapy

Instructions: This is your comprehensive information sheet. All relevant, personal information is gathered to equip the therapist with essential information used to deliver an optimal, results driven program. Please answer all questions accurately, honestly, and as detailed as possible.

Disclaimer: Please recognize the fact that it is your responsibility to work with your physician before, during, and after seeking consultation. As such, any information provided is not to be followed without the prior approval of you physician. If you choose to use this information without the prior consent of your physician, you are agreeing to accept full responsibility for your decision.

Part 1: Basic Information

Name: Gender: D.O.B: Age

Email: Contact Number:

Part 2: Session Information

What is you main reason for receiving therapy?

What specific goals would you like to receive from therapy?

How did your symptoms begin? When did symptoms begin?

Please mark on the figures where symptoms are located:

Are you currently, or have been, under medical supervision for this problem? YES NO

Have you had any tests for this problem (x-rays, MRI, CT-scan)?

Please describe your symptoms. Circle all that apply:

-Dull -Ache -Burning -Sharp -Periodic -Constant

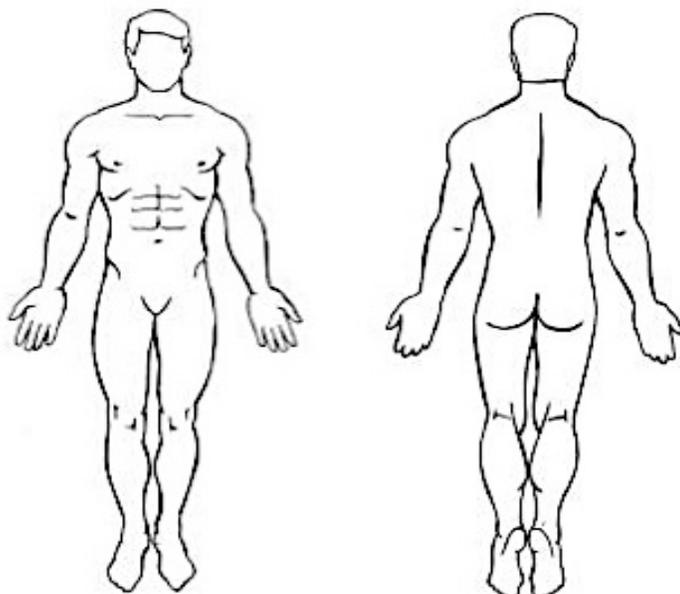
-Sore -Stiff -Numb -Tingling

What makes your symptoms better or worse?

Blank lines for symptom description

Do you have chronic or frequent pain?

On a scale from 1-10, 10 being the most severe pain possible, what is your discomfort level now?



Part 3: Physical/Lifestyle Factors

Please list any supportive braces worn? _____ Do you wear orthotics? YES _____ NO _____

Have you ever had chiropractic treatment? YES _____ NO _____ How often? _____

Have you experienced any bodywork (massage, acupuncture, etc)? YES _____ NO _____ If so, what type? _____

How often do you receive bodywork? _____

Are you currently exercising regularly? YES ___ NO ___ How does exercising impact your symptoms? _____

Do you currently stretch? YES ___ NO ___ If so, how often? _____

Do you believe flexibility is an important part of fitness and overall health? YES _____ NO _____

What percentage of your day is spent sitting? _____ Standing? _____ Driving? _____ Physical Labor? _____

How do you rate your posture? _____

Part 3: Medical History

Have you been diagnosed with any health problems? If so, please list the condition(s): _____

Are you currently on any medications (including over-the-counter medication like ibuprofen)? If so, please list them.

Please list any supplements that you are currently taking: _____

Are you currently under care of a physician? YES _____ NO _____ If yes, please explain: _____

Please list any injuries, accidents or surgeries and date of event: _____

Are there any other medical conditions that the therapist should be aware of? _____

The above information is accurate and true to the best of my knowledge. If there are any changes in my current level of health, I will inform the person I am being treated by of my condition. I understand that this business does not diagnose or treat illness and/or disease and does not prescribe medications. I agree to pay my account with this business in accordance with the regular rates and payment terms. If, for any reason cancellation is necessary, I will give a 24-hour notice. I understand that if I do not give this notice, I will be charged for the appointment unless it can be filled. The owner will determine emergency cancellations. It is agreed that any claim of liability is hereby waived.

Signature

Date