Confidential Client Information Sheet

Name_____Date_____
(last) (first)

Address_____

City_____State_____Zip_____

Email_____Age_____DOB_____

Phone Numbers – home(_____)_____work(____)_____

mobile(_____)_____

Occupation_____Employer_____

Employer's Address_____

City_____State_____Zip_____

Personal Physician_____Phone Number(_____)_____

Emergency Contact (relationship)_____Phone(____)_____

Who should we thank for this referral?_____

Hobbies/Sports_____

Goals you wish to attain through your work with Perfect Postures, Inc

_____

_____

Medical History for Perfect Postures, Inc

History of Present Concern(s)

Location & Type (i.e. sharp, tingling, etc)	0-10 pain rating (10=worse)	How long?
1._____	1._____	1._____
2._____	2._____	2._____
3._____	3._____	3._____
4._____	4._____	4._____

What improves symptoms? (i.e. rest, sitting, pain meds, bending forward, etc)

_____

What worsens symptoms? (i.e. standing too long in one spot, golfing, sitting in car, etc)

_____

Past and present treatments: Please quantify the degree of help each type of treatment has given you as well as how many sessions. (1=little help, 10=most helpful)

1._____

2._____

3._____

4._____

Past Medical History

Surgeries:_____

Accidents/Injuries:_____

I declare that the above information is true and accurate to the best of my knowledge.

Signature_____Date_____