



Confidential Client Information Sheet

Name _____ Date _____
(last) (first)

Address _____

City _____ State _____ Zip _____

Email _____ Age _____ DOB _____

Phone Numbers – home(_____) _____ work(_____) _____
mobile(_____) _____ Cell provider _____

Please circle appointment reminder type: Email SMS text

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 _____