Client Information

Name_____ **Date**_____

Street_____ **Apt#**_____

City_____ **State**_____ **Zip** _____

Email_____ **Occupation** _____ _____

Home Phone_____**Cell**_____

Age_____ **Date of Birth**_____ **Marital Status: S M D W**

Spouse or S/O _____

Children with ages:_____

Referred by: _____

Present Complaint: _____

First Occurrence_____

What aggravates it? _____ **What lessens it?** _____

Is it worse during certain times of the day? _____

Interfering with work, sleep or daily routine? _____

Is it getting worse? _____

Other practitioners seen for this _____

Other Symptoms:

Headaches_____
Chronic Pain _____
Low Energy _____
Digestive Difficulties _____
Sleep problems _____
Other Symptoms_____

What do you hope to gain in coming here?_____