

## 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? \_\_\_\_\_