

CLIENT INFORMATION

Name: _____

Home Address: _____

_____ E-Mail _____

Home Phone _____ Work Phone _____

Occupation/Employer _____

DOB ___/___/___ Age ___ Height ___ Weight ___ Sex M F

Private Physician _____ Phone _____

Emergency Contact _____ Phone _____

1. Have you had or do you now have any disorders mentioned below?

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Back Trouble | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Hernia | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Bleeding | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Other _____ | | |

If yes, please explain: _____

2. Any past history of hospitalizations, operations and/or serious injuries? Please provide specific details. _____

3. Are you currently taking any medications (including non-prescription)? Please provide specific details. _____

4. Answer Yes or No to the following:
- Do you have or have you had any pain or tightness in the front or back of your chest? Y N
 - If yes, is it during exertion and/or with anxiety? Y N
 - Have you ever been told you have an abnormal EKG? Y N
 - Do you ever have swelling of the feet and/or ankles following long periods of standing or intense physical activity? Y N
 - Does your heart ever beat irregularly? Y N
 - Has a physician ever said you have a heart murmur? Y N
 - Do you get cramps in the back of your legs when you walk? Y N
 - Have you noticed any circulatory problems in your feet or hands? Y N
 - Do you have chronic lower back pain? Y N
 - Do you have pain in your legs and/or feet? Y N
 - Do you have joint pain, stiffness, swelling or instability? Y N
 - Do you have troubles walking/jogging or in using your hips, shoulders or knees? Y N

5. Please note any additional information / conditions we should be aware of. _____

| | | | |
|------------------------------------|----------------|------------------------------------|-------------------------------|
| Office Use Only: | | | |
| Month/Year | _____ | <input type="checkbox"/> Agreement | <input type="checkbox"/> Copy |
| <input type="checkbox"/> CC Auth # | _____ | | |
| <input type="checkbox"/> Check # | _____ | | |
| <input type="checkbox"/> T-Shirt | Referral _____ | | |