

Able Bodyworks - Client Information

Name: _____ HomePhone: _____

Address: _____ WorkPhone: _____

City _____ State: ___ ZIP: _____ CellPhone: _____

Email: _____

Birth Date: _____ Referred by: _____

Emergency contact: _____ Phone: _____

Physician: _____ Phone: _____

Check all that apply

- | | |
|--|---|
| <input type="checkbox"/> Do you suffer from stress? | <input type="checkbox"/> Have you had any broken bones in the last two years? |
| <input type="checkbox"/> Do you suffer from back pain? | <input type="checkbox"/> Have you had an accident in the last two years? |
| <input type="checkbox"/> Do you have frequent headaches? | <input type="checkbox"/> Have you had surgery? |
| <input type="checkbox"/> Do you have joint swelling? | <input type="checkbox"/> Do you have numbness or sensitive areas? |
| <input type="checkbox"/> Do you suffer from arthritis? | <input type="checkbox"/> Do you have circulatory problems? |
| <input type="checkbox"/> Do you have varicose veins? | <input type="checkbox"/> Do you bruise easily? |
| <input type="checkbox"/> Do you have epilepsy or seizures? | <input type="checkbox"/> Are you wearing contact lenses? |
| <input type="checkbox"/> Do you have osteoporosis? | <input type="checkbox"/> Are you wearing dentures? |
| <input type="checkbox"/> Do you have any allergies? | <input type="checkbox"/> Have you suffered from trauma? |
| <input type="checkbox"/> Do you have diabetes? | <input type="checkbox"/> Have you been sexually abused? |
| <input type="checkbox"/> Are you pregnant? | <input type="checkbox"/> Do you have any other medical conditions? |
| <input type="checkbox"/> Do you prefer to be clothed? | <input type="checkbox"/> Are there areas that you do not want worked? |

Comments: _____

Please list all pertinent medications: _____

Client Signature: _____ Date: _____

Notes: _____

It is important to fully disclose all pertinent medical conditions so that I can treat you more effectively and avoid techniques that may be contraindicated.