

Client Report Form

Date: _____

Last name: _____ First name: _____ Age: _____

Please, describe the ailment or injury.

Please, indicate the time period during which you sustained the injury or during which the ailment began.

Please, describe the physical activity during which you first noticed the symptoms or during which the injury was sustained:

Please, list physical activities in which you are normally involved:

Please, indicate if any of the following conditions may have applied to you in the past.

- | | | | |
|---------------------|------------------------------|-----------------------------|-----------------------------------|
| Epileptic seizures | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| High blood pressure | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Heart disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Surgery | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If yes, please list dates: _____ |
| Digestive problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Pregnancy | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If yes, please list year(s) _____ |
| Allergies | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |

If yes, please, list allergies:

Please, indicate if any of the following conditions apply to you currently.

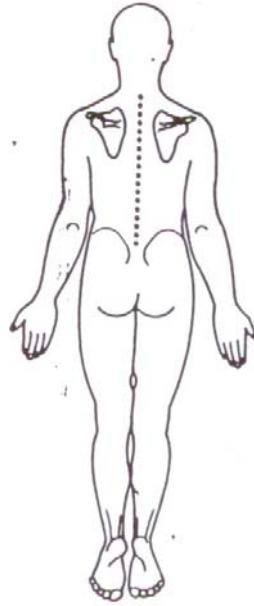
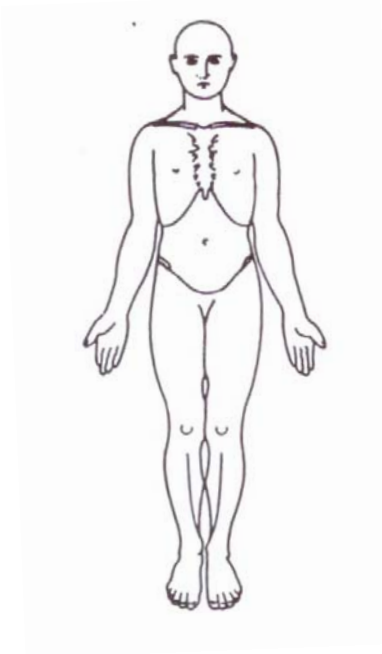
- | | | |
|---------------------|------------------------------|-----------------------------|
| Epileptic seizures | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| High blood pressure | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Digestive problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Pregnancy | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Medications | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Allergies | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If yes, please, list allergies:

- Please, continue on reverse side -

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Please, mark the diagrams below to indicate the location of the symptoms or injury.



Please, state your goal with regard to your health:

Additional information:
