Name____ Date_______________

DOB ____________ Telephone ____________________ Email___________________________________

Have you Ever Been Treated by a Physician For:

Arthritis Y__ N__
Chronic Fatigue Syndrome Y___ N___
Diabetes Y___ N___
Fibromyalgia Y___ N___
Heart Disease Y___ N___
High Blood Pressure Y___ N___
Gastric Reflux Y___ N___
Glaucoma Y___N___
Multiple Sclerosis Y___ N___
Orthopedic/Joint (shoulder/elbow/spine/hip/knee) Problems
___Anterior Cruciate Ligament Knee Injuries
___Facet Joint Syndrome
___Herniated or Bulging Disk
___Spondylolisthesis
___Stenosis
___Total Hip Replacement
Osteoporosis Y___N___
Peripheral Neuropathy (numbness/tingling/diminished sensation) Y___N___
Rheumatoid Arthritis Y___N___
Other ____

Are you pregnant? Y___N___

Prior Deliveries:____

Prior Surgeries:____

____

____

Prior Injuries, Musculosketal and Neuromuscular Issues:

Adhesive Capsulitis (frozen shoulder) Y___N___
Carpal Tunnel Syndrome Y___N___

Plantar Fascitis Y___N___
Rotator Cuff Impingement Y___N___
Thoracic Outlet Syndrome Y___N___
Other ____

Do you carry a list of your current medications? Y___N___
Activity Level/Exercise Frequency:______________________________
____
____

Prior Movement Experience? (dance, Feldenkrais, yoga, etc…)
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Goals:____
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Notes/
Comments:____
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