Client Identification Label

CLIENT INFORMATION SHEET

Name: ____ Date: ____________
Hand Dominance: □ Right □ Left Age: ____________

How did you hear about our services? □ Doctor □ Nurse practitioner □ Chiropractor □ Friend/family
□ Telephone Book □ Internet □ Other: ________________________________

WORK INFORMATION
Are you currently employed? □ Yes □ No
What is your job title? ____
What are your job duties/responsibilities? __________________________________
____
What is your work status? □ Full-duty □ Full-time □ Part-time □ Restrictions □ Retired
□ Light-duty □ One-handed □ Off-duty □ Disability

PAST MEDICAL HISTORY
Please circle any past or current medical problems you may have:

Cardiac Heart Failure	Cancer	Stroke
Pacemaker	High Blood Pressure	Head Injury
Cardiovascular Disease	Diabetes	Neck or Back pain
COPD	Gout	
Irregular Heart rate	Arthritis	

Other (please list): ____

Please check if you are a □ non-smoker □ smoker

Please list any previous neck, shoulder, arm, and/or hand surgeries and/or injuries:____________________
____

Do you have any metal implants or artificial joints? □ Yes □ No

Do you have any allergies? Please specify: ____________________________________

Do you have allergies to shellfish and/or strawberries? □ Yes □ No

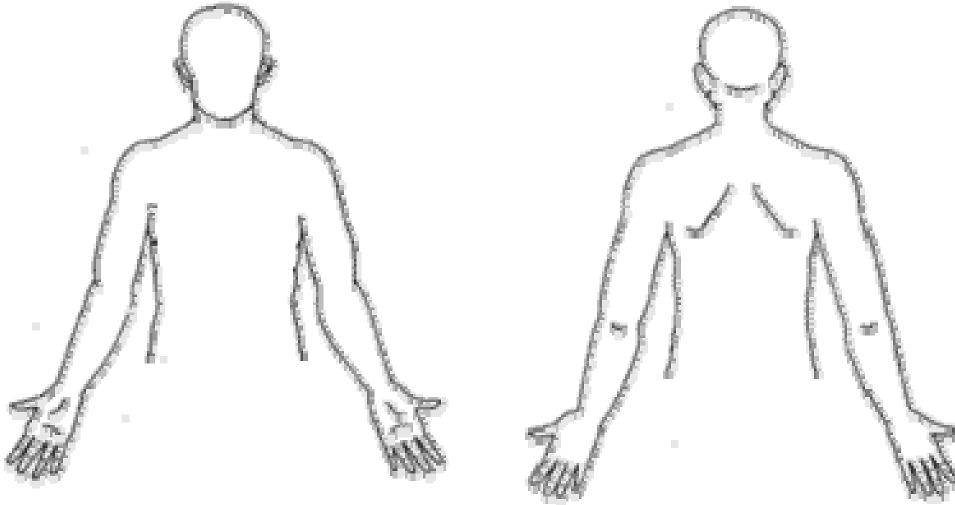
Are you taking any medications? Please list: ____________________________________
____

Have you had any of the following tests performed for your current problem:

Test			***Results:***
X-rays	□ Yes	□ No	____________________
Nerve conduction test	□ Yes	□ No	____________________
EMG	□ Yes	□ No	____________________
CT Scan	□ Yes	□ No	____________________
MRI	□ Yes	□ No	____________________

PLEASE SEE OVER

SYMPTOMS
Please use this diagram to circle any problem areas:



PAIN
On a scale of 0 – 10, circle the number that best describes the intensity of your worst pain in the last week.
0 = no pain, to 10 = worst pain you could imagine.

0 1 2 3 4 5 6 7 8 9 10

TELL US ABOUT YOUR CURRENT CONDITION…
Date of injury: ______________________________

Date of surgery: ______________________________

What happened? Briefly describe your current problem/symptoms: ______________________________

____

Have you ever had these symptoms before? When? ______________________________

Previous treatment for this problem? ______________________________

What makes it better? ______________________________

What makes it worse? ______________________________

Have you tried any braces and/or splints? ______________________________

How does this impact your life? What can't you do as a result? ______________________________

____

What hobbies/recreational activities do you enjoy? Are you having any difficulties performing these activities?

____

What are your goals in coming to therapy? ______________________________

____

THANK YOU!