Preferred Client Information

Name: (Mr./Mrs./Ms.) circle one **Date:___/___/_____**

Last:_____ ***First***:_____

Birth Date: ___/___/_____ ***Current Age:***____ ***Profession:*** _____

Married / Partnered / Single / Divorced / Widowed *Number of Children* _____

Contact Information:

Telephone: Work:_____ Home:_____

Email:_____ Cell:_____

Can we send appointment reminders to your cell via text? (Yes / No) Provider_____
(ex: Sprint, AT&T, etc.)

***Address*:**

Line1:_____

City:_____ State: _____ Zip:_____

Emergency Contact:

Name:_____ Relation: _____Phone:_____

Were you referred to us by someone? (Y / N) circle one

If yes, by whom? _____
If no, how did you hear about us? _____

What is your chief complaint? _____

What are your other major complaints? _____

Have you ever had: a seizure? (Y / N) a stroke or brain bleed? (Y / N) a major head injury? (Y / N)

Do you have any children / nieces / nephews / grandchildren with health challenges (mental / emotional / physical)? _____

For Office Use Only:

Initial Session Date: ___/___/____ Trainer Name:_____
Medicated at time of Asses? (Y/N) Type:_____
Notes:_____
_____
_____
_____
_____