CLIENT INTAKE FORM

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Please take your time in providing the following information. The questions are designed to help me make our time together as productive as possible. **All information is confidential**. If at any time you questions regarding your therapy session, please let me know.

Date of first appointment:_____

Referred by:

- ☐ Medical Provider:_____
- ☐ Insurance Provider:_____
- ☐ My Website: jodireyersonphsicaltherapy.com
- ☐ Friend/Family:_____
- ☐ Other:

DO YOU HAVE A HISTORY OF THE FOLLOWING?

- Accident
- Neck pain
- Whiplash
- Headaches
- Shoulder pain
- Upper back pain
- Mid-back pain
- Low back pain
- Joint aches
- Limited movement
- Broken bone
- Sprains
- Seizures
- Abdominal pain
- Nervous tension
- Arthritis, bursitis, gout
- Fibromyalgia
- Wear contacts
- Scoliosis
- Surgery
- Allergies to perfumes/oils
- Colitis
- Sciatica
- Mastectomy
- Breast augmentation
- Diabetes
- Varicose veins
- High blood pressure
- Stroke
- Heart attack
- Cancer
- Carpal tunnel
- HIV/AIDS
- Hepatitis

What types of bodywork have you received in the past?

Briefly, what brings you in today?

When did your problem start? Within the last:

- ☐ 30 days
- ☐ 6-12 months
- ☐ 2 years
- ☐ More than 2 years

What areas of your life have been affected because of this problem?

What would you like to accomplish during your therapy sessions?

Please list any medications, herbs, or supplements. Be sure to include the condition you are using it for. Continue on back or provide a separate list.

Medication/Supplement	**Dosage**	**Condition**	**Started/Stopped**

How would you rate your current physical health?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

If you are having problems, what is the issue?

- ☐ Falling asleep
- ☐ Staying asleep
- ☐ Awakening early
- ☐ Sleep apnea

Please list any other specific sleep problems you are currently having:

How many times per week do you generally exercise? _____
What types of exercise?

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

What do you do for work?

How stressful your day-to-day life?

If you did not have your current problem, how would your life change?