3220 Uddenberg Lane, Ste 3
Gig Harbor, WA 98335

Client Information

General Information

First Name: _____ M.I. ____ Last Name: _____

Address: _____ City: _____ST: _____ Zip: _____

Home Phone: _____ - _____ - _____ Cell:_____ - _____ - _____

Birth Date: _____ Age: ____ Emergency Contact: _____Ph: _____ - _____ - _____

E-mail: _____

Occupation / Daily Activities: _____

Current Health Goals: _____

_____

Current Health Conditions

Musculo-Skeletal
o Artificial Joint: Hip / Knee / Shldr
o Arthritis
o Headache: front / back / side
o Jaw pain / TMJ Disorder
o Joints: fusion / pain / swelling
o Osteoporosis / Osteopenia
o Strain / Sprain
o Tendinitis

Circulatory & Respiratory
o Asthma / Sleep Apnea / Bronchitis
o Blood clot
o Heart condition
o High blood pressure
o Stroke
o Varicose veins

Skin
o Rash / Allergy
o Warts

Digestive
o Acid reflux or Gastric ulcer
o Diverticulitis
o Gastric Band/Sleeve/Bypass
o Irritable Bowel Syndrome

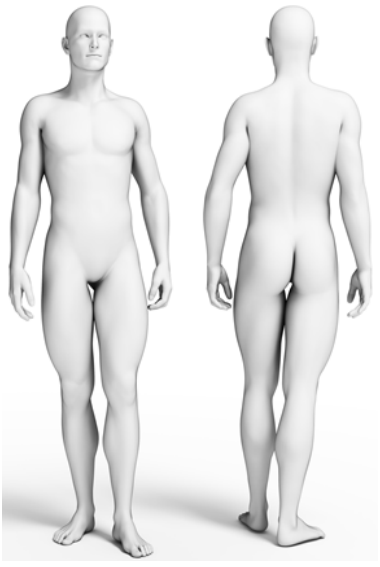
Nervous System
o Concussion / Traumatic Brain Injury
o Fibromyalgia
o Herpes / Shingles
o Multiple Sclerosis / Parkinson's
o Other:
_____

Other
o Diabetes
o Cancer
o Implanted Medical Device:
_____
_____
o Accidents (0→5 years ago):
_____
_____
_____
o Surgeries (0→1 year ago):
_____
_____
_____
o What else would you like us to know?
_____

Acknowledgements & Policies

- I certify that this current health care information is accurate. I agree to notify my therapist to any changes in my physical condition prior to additional treatment.
- I acknowledge that a minimum notice of **12 hours is required for rescheduling and cancellation**. Less notice may result in a charge and/or denial of additional therapy.

Please Draw X's or Circles to Show Problem Areas.



Signature:

_____

Date: _____