New Client Intake Form FST

Name:_____ **Referred By:**_____

Address: _____ **Phone – Work:**_____

City/State/Zip: _____ **Phone – Home:** _____

Birthday: _____ **Mobile:** _____

Occupation: _____ **E-Mail:** _____

Emergency Contact: _____ **Phone:** _____

General Information:

What is your main reason for coming to therapy?

_____

What specific goals would you like to achieve from therapy?

_____

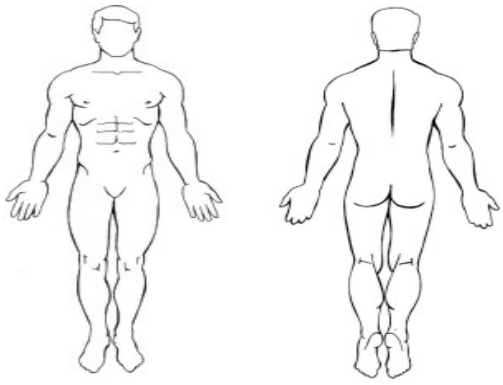
How and when did the symptoms begin? _____

How long have you had these symptoms? _____

Are you currently, or have you ever been, under medical supervision for this problem? Y/ N

_____

Where are your symptoms located? Please mark the areas on the figures below:



Comments:

Have you had any tests for this problem; such as x-rays, MRI or CT scans? Y/N

_____

Describe the symptoms. Please check all that apply:

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dull	**Ache**	**Burning**	**Sharp**	**Periodic**	**Constant**	**Sore**	**Stiff**	**Numb**	**Tingling**

On a scale of 0 to 10 with 10 being the most severe imaginable discomfort, what is your discomfort level right now?

_____

What makes it better or worse?

_____

What time of day is the pain worse?

_____

What percentage of your day is spent sitting? _____, standing? _____, driving? _____

Are your symptoms worse at the end of the workday? Y / N_____

How would you rate your own posture? Poor Fair Good Excellent

Medical History

Please list any recent injuries, illnesses, or surgeries:

_____

_____

_____

Have you had any accidents, auto or other? _____

Have you ever had any major surgeries? _____

Scoliosis _____ Arthritis _____ Sciatica _____

The above information is accurate and true to the best of my knowledge. If there are any changes in my current level of health, I will inform the person here that I'm seeing of my condition. I understand that this office does not diagnose or treat illness or disease and does not prescribe medications. I agree to pay my account with this office in accordance with the regular rates and payment terms. If, for any reason cancellation is necessary, I will give a 24-hour notice. I understand that if I do not give this notice, I will be charged for the appointment unless it can be filled. It is agreed that any claim of liability is hereby waived.

_____ _____

Signature **Date**