## Northside Neuromuscular Center Confidential Client Information Form

Today's Date:	Email Address	s:		
Name:		Phone H: ()	W: ()	
Address:		City:	State: Zip:	
Birthdate:	Age:	Sex: M	F Marital Status: Children	
Occupation:		_ Referred by:		
Cell #:		Phone #:		
1. Have you received an	y treatment fo	or your current con	dition?	
2. What areas of your bo	ody are experi	encing pain or disc	comfort?	
Please mark with an "X", a	ny major or m	inor complaints.		
( )	(==	.),	For Therapist Use Only	
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3. Do you have any	y old or new inju	ries? Any areas prone	e to injury?					
4. Are you currently taking any medications? If yes, please list								
5. Have you ever, o	or do you now ha	ave any of the followin	 ig:					
Allergies to oil or perfumes		Diabetes	Nec	Neck, mid/lower back pain				
Varicose veins		Headaches	Hig	High blood pressure				
Decreased range of motion		Pregnancy	Per	Persistent abdominal pain				
Nervous tension		Sprains	Joir	Joint ache				
Broken bones		Seizures	Cor	Constipation				
Surgeries		Accidents	Wh	Whiplash				
6. Do you have any	other conditions	s not listed above?						
7. Do you have any Irritated sk			en cuts, bruises	scrapes or burns				
Sunburn	Wir rusir	Open cuts, bruises, scrapes or burns Inflammation or swelling						
8. Habits:	Heavy	Moderate	Light	None				
Alcohol	11041	moderate	g					
Coffee		<del></del>						
Exercise								
Weekly sugar								
Consumption								
-	snorts do vou na	rticipate?						
10. Do you have a ti	alling programs	How often do you in	aiii:					
changes. I understand	that a massage the	ditions and physical limita erapist cannot diagnose ar I am responsible for consi	ny illness, disease	or any other medical,				
I agree to pay for	all services render	ed at the time they are re	ndered unless prio	or arrangements have been				
made. Only cash or chec	ck is accepted as pa	ayment for services render	red.					
Client Signature or Guar	dian of Minor		Date:					