CLIENT QUESTIONNAIRE

(Use back of form if more space needed)

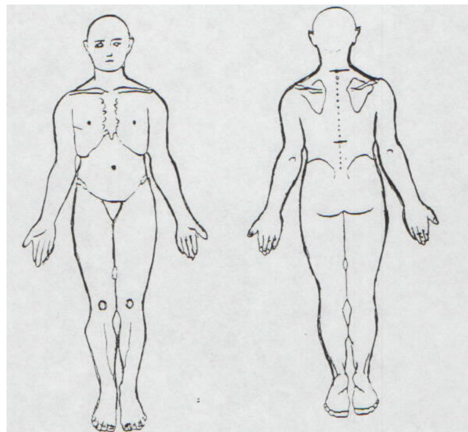
Name: ________________________________ **Age:** ____ **DOB:** ___________ **Date:** ____________
Address: ____
Phone (h): _______________________**(c)**_______________________**(w)**_______________________
Email: (h): ___________________________________ **(w):** _________________________________
Occupation: ____
Referred by: ____
Primary MD: ____
Current medications and vitamins: ____

Diagnosis/symptoms/complaint: ____

What treatments have you tried to address this issue? (Massage, chiropractic, acupuncture, PT, steroid injections, etc.) ____
Mechanism of injury: ____
Goals for therapy: ____

Pain

Please indicate on the drawing all areas where you feel pain. Shade darker where the pain is most intense.



Rate your pain **AT REST** and **WITH ACTIVITY** on a scale of 0-10, with 10 the most severe.

Primary pain site ____ At Rest _____ With Activity _____
Secondary pain site ____ At Rest _____ With Activity _____

Assess your Capacity for Activity on a 0-10 scale 0 = Fully unable 10= Fully able

Work _____ Daily Tasks _____ Leisure Activities _____

Exercise – Do you exercise regularly? Yes___ No___
Describe frequency and type of exercise ____

Mend Well therapists provide a wellness program. Our manual therapy techniques address the whole body in order to achieve optimal results. Health insurance companies do not recognize wellness programs as medically necessary. Our services are private pay.

____ **Client Signature**

Medical History

Use the back to specify details if you need more room.

Yes No

___ ___ Autoimmune disease (Rheumatoid arthritis, Celiac disease, Lupus erythematosus, etc.)

___ ___ Cancer / Tumors
Type ____
Treatment (chemo, radiation, surgery) ____

___ ___ Circulation problems____

___ ___ Dental History (TMJ pain, grinding teeth, root canals, use of mouth guard, etc.)

___ ___ Diabetes
Insulin Dependent Yes_____ No_____

___ ___ Falls in the past 3 months, or significant trauma

___ ___ Fractures – List type or bone(s) fractured, and surgery if that was necessary.

___ ___ Gastrointestinal problems (IBS, food allergies, reflux, ulcers, constipation/diarrhea, etc.)

___ ___ Genitourinary problems (stress incontinence, prostate disease, prolapsed bladder, etc.)

___ ___ Head Injury (any impact to the head)

___ ___ Headaches – List frequency and type, such as migraine, stress, or sinus headache.

___ ___ Heart Condition (high blood pressure, coronary artery disease, heart attack, pacemaker, etc.)

___ ___ Joint Replacements - List joint(s) and date(s) of surgery.

___ ___ Mental Health____
(anxiety, depression, etc.)____
(memory loss, dementia, Alzheimer's etc.)____

___ ___ Muscle sprain / strain / tendonitis____

___ ___ Neurological Conditions (Parkinson's, seizures, multiple sclerosis, etc.)

___ ___ Osteopenia / Osteoporosis
Bone Scan Yes____ No____ Date ____ Results____
Loss of Height Yes_____ No_____

___ ___ Respiratory Problems (Asthma, pneumonia, bronchitis, COPD, pain with deep breath, etc.)

Number of pillows used when sleeping _______

___ ___ Sensation problems (peripheral neuropathy, numbness/tingling, Reynaud's, etc.)

___ ___ Surgery (for any reason, even if long ago. Include any implants.)

___ ___ Visceral System (Issues with organs such as the appendix, kidneys, gallbladder, liver. Organ transplant.) ____

___ ___ Is there anything else we should know that will help us plan your treatment? ____

For Women Only

YES	**NO**	
___	___	Endometriosis

___	___	Pregnancy
		# Pregnancies _____
		# Births _____
		    # Vaginal births _____
		    Episiotomy - Yes___ No___
		    # C-Sections _____

___	___	Post Menopausal
		At age _____
		    Natural _____
		    Surgical _____

___	___	Prolapsed uterus
___	___	Implants (IUD, mesh, etc.)
___	___	Other gynecological issues - ____ ____ ____ ____