Client Information Form

(All Information Confidential per HIPAA Privacy Rule)

Name : _____ Date : _____

Address : _____ City : _____

State : _____ Zip : _____ Male / Female Age : _____

Phone# : Home : _____ Cell : _____

eMail : _____

Marital Status : Single Married DeFacto Widowed Separated Divorced

Do you have children? Yes / No If Yes, how many? _____

Occupation : _____

Hobbies / Recreation : _____

How did you find out about me? _____

Briefly describe the health issue(s) you would like to resolve : _____

_____

Do you regard your health issue(s) as : Severe Moderate Mild

What other forms of therapy have you used to resolve your health issue(s)? _____

_____

How successful were they? Very Successful Partly Successful Not Successful

List previous/other illnesses/accidents/surgery you have had : _____

_____

_____

List any current medications : _____

_____

On a scale of 1-10, rate your current pain level (1 = Low, 10 = High) : _____

In what way do you expect your health issue(s) to improve following consultations with your NST practitioner? _____

Over what period of time do you expect total recovery to occur? _____

How will you know when you are totally recovered? _____

List any supplements you currently take (vitamins, minerals, amino acids, homeopathic etc;)

_____

Daily water intake (not including fruit juice, soft drinks, tea, coffee, alcohol)? _____

Briefly describe your diet : _____

What are your favorite foods? _____

Are your bowel movements : Daily Less than daily

How often do you exercise? Daily 3-5 x per week Weekly Occasionally Never

On a scale of 1-10, what is your daily energy level? _____

On a sale of 1-10, where do you want your daily energy level to be? _____

Client Information Form

(All Information Confidential per HIPAA Privacy Rule)

Do you smoke? Yes / No If Yes, how many a day? _____

Do you use orthotic appliances in your shoes? Yes / No

Do you experience : Back Pain Neck Pain Other Physical Pain?

Do you experience : Ringing in the ears Clicking/Popping of the Jaw Facial Pain?

If Female, are you pregnant? Yes / No If Yes, how advanced? _____

Menstrual Cycle : Regular Irregular Painful Heavy Menopausal Other

Do you have Breast Implants? Yes / No

(***Optional***) Check any of the following issues which relate to you, and place two checks against those you would like to deal with :-

Nervousness	Depression	Fear	Shyness
Sexual problems	Suicidal thoughts	Separation	Divorce
Finances	Drug use	Alcohol use	Friends
Anger	Self Control	Unhappiness	Sleep
Stress	Work	Relaxation	Headache
Tiredness	Legal matters	Memory	Ambition
Energy	Insomnia	Temper	Education
Nightmares	Concentration	Making Decisions	Marriage
Children	Career choices	Inferiority	Thoughts
Parenting	PMS	Unpleasant memories	Social skills
Motivation	Pain	Regrets	Enemies
Dizziness	Grieving	Anxiety	

Is there anything else in your life you would like to :-

Stop doing Start doing Do better Do differently

Briefly explain : _____

_____

Consent for NST treatment :-

_____ _____

(Signature) (Date)

Disclaimer :

NST Practitioners do not dispense medical advise, diagnosis, or prescriptions, either directly or indirectly. Soft tissue moves are performed ONLY, and are within the scope of a Licensed Massage & Bodywork Therapist (LMBT) Rules Section .0500.

Whenever persons find themselves in need of treatment by a medical professional, we encourage them to see their duly licensed physician accordingly. Those who receive the NST procedures, do so entirely at their own responsibility.