

## CLIENT REGISTRATION AND HISTORY

Name: \_\_\_\_\_ Home Phone \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Hours of Work per Week \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ DOB \_\_\_\_\_ Marital Status \_\_\_\_\_

List number of children and ages or age range: \_\_\_\_\_

Referred by: \_\_\_\_\_

Reason for Therapy \_\_\_\_\_

Family Physician: \_\_\_\_\_

Have you received other types of therapies?

Name of Therapy

Description

Therapist

<u>Name of Therapy</u>	<u>Description</u>	<u>Therapist</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone \_\_\_\_\_

\_\_\_\_\_ Work Phone \_\_\_\_\_

How many hours of the following do you do daily/weekly?

Walking \_\_\_\_\_ Yoga \_\_\_\_\_

Running \_\_\_\_\_ Biking \_\_\_\_\_

Calisthenics \_\_\_\_\_ Machines \_\_\_\_\_

Weight Lifting \_\_\_\_\_ Sports/Athletics \_\_\_\_\_

Aerobics \_\_\_\_\_ Meditation \_\_\_\_\_

Other \_\_\_\_\_

List any medications you are currently taking

Name of Medication

Reason

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List any vitamin or herbal supplements you are currently taking

Name of Supplement

Reason

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List any hobbies or recreational programs in which you participate

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