



CLIENT PROFILE

Name: _____ Birthdate: _____ Occupation: _____

Address: _____ City: _____ Zip: _____

E-mail: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Referred by: _____

THIS OFFICE DOES NOT RELEASE CLIENT INFORMATION TO THIRD PARTIES. IW SENDS EMAIL OR POST MAIL FOR SEASONAL OCCASIONS

GENERAL & MEDICAL INFORMATION

Have you ever received chiropractic care? YES NO How recently? _____

Have you ever received a professional massage? YES NO How recently? _____

What type of massage do you prefer? LIGHT MEDIUM FIRM OTHER _____

Have you ever received a BodyTalk Session before? YES NO How recently? _____

Have you ever had a nutritional consultation before? YES NO How recently? _____

What were the recommendations? _____

Do you suffer from stress? YES NO Do you have diabetes? YES NO

Do you have high blood pressure? YES NO Do you suffer from arthritis? YES NO

Do you experience frequent headaches? YES NO Are you wearing contact lenses? YES NO

Do you have any allergies? YES NO Are you taking any medications? YES NO

Are you sensitive to touch or pressure in any area? YES NO Do you have cardiac or circulation problems? YES NO

How many hours a night do you sleep? _____ Have you experienced any injuries, illness or surgeries in the past 2 yrs? YES NO

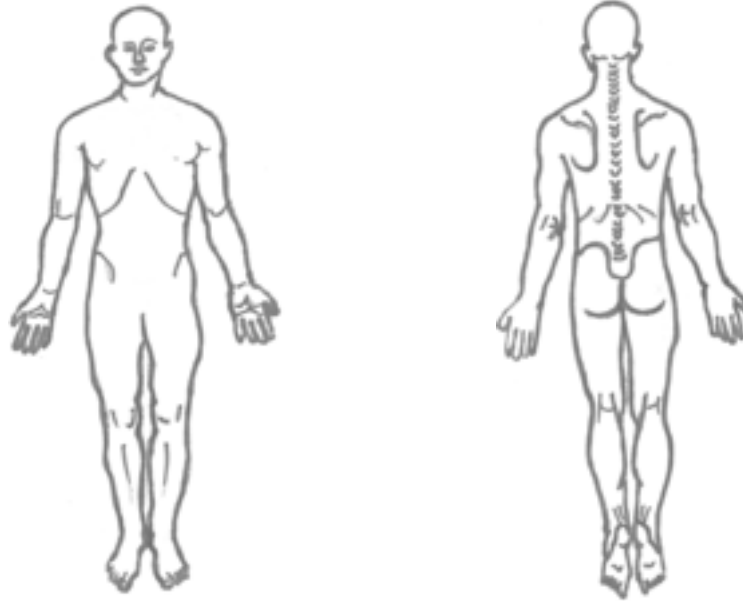
Is your sleep restful? YES NO

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN BELOW:

PLEASE CONTINUE ON BACK PAGE



Please mark on the Diagrams below the areas discomfort in your body:



Please list your health concerns and symptoms.

What are your MAIN/LONG TERM GOALS?

Emergency Contact Person _____ Emergency Phone _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

DISCLOSURES:

I understand that if medical examination and diagnosis is needed for my physical or mental condition, I should see a medical specialist. I agree to keep the IW practitioners up to date during my session regarding my comfort. I also agree to update any changes in my IW general and medical profile. I hereby authorize IW practitioners to administer treatment. CLIENT INITIALS: _____

I acknowledge that any appointment cancelled without twenty four hours notice will be charged to me. CLIENT INITIALS: _____

IW NOTES: