Name_____ Date_____

Email_____ Phone_____

Address_____

DOB_____ Employment _____

Heard about clinic from _____

Current Complaint(s) _____

_____

_____

History Of _____

_____

_____

_____

What would you like to be able to do that you currently are not able to? (other expectations?)

_____

_____

_____

Patient's Birth _____

_____

Operations _____

_____

Medications _____

Accidents/Injuries _____

_____

Dental History _____

For Women: Births _____

_____

Disease Processes _____

_____

Occupations _____

_____

Sports _____

_____

Exercise _____

_____

Musical Instruments _____

Hobbies _____

_____

Other _____

_____

Other Methods Tried _____

_____

MEASUREMENTS

Kraus/Weber Test

Abs + _____ Abs - _____ Psoas _____ Upper Back _____ Low Back _____ Back/Ham Flex _____

Long 2nd Toe _____ Scoliosis _____

Quad Test _____ _____ Heel Cord _____ _____ Kyphosis _____ ____ Shldr Flex Test _____ _____

Left Right Left Right Left Right Left Right