SPINAL FLOW WELLNESS

Name: _____

Date: _____

Email: _____

Phone: _____

DOB: _____

CLIENT QUESTIONNAIRE

Why are you here?

_____

_____

What symptoms are you experiencing now?

_____

_____

How long have you had these symptoms?

_____

_____

Is there anything I should know?

_____

_____

Please circle Yes / No where applicable

Pain & Stress Status

Are you currently in pain? Yes / No

Are you currently suffering stress? Yes / No

Are you taking medication? Yes / No

Do you want to achieve pain or stress freedom? Yes / No

Are you prepared to make changes in your life to be pain and stress free? Yes / No

CLIENT QUESTIONNAIRE

Please tick the relevant symptoms you experience

Neck Pain ____ Numbness in Fingers ____ Nervousness ____ Stiff Neck ____

Shoulder Pain ____ Tension & Irritability ____ Headaches ____

Cold Feet / Hands ____ Fatigue / Sleeping problems ____ Dizziness ____

Loss of smell / Taste ____ Depression ____ Fainting ____ Cold / Flu ____

Chronic Fatigue ____ Ears Ring ____ Allergies ____ Pins & Needles / Legs ____

Balance Loss ____ Pain in Mid-spine ____ Shortness of Breath ____ Numb Toes ____

Cold Sweat ____ Weight Problems ____ Chest pain ____

Hearing problems ____ Stomach / Digestive Problems___ Fever ____

Lights bother eyes ____ Constipation / Diarrhea ____ Loss of Memory____

Menstrual Pain ____ Pins & Needles in Arms ____ Migraines ____ Stress ____

Difficulty Breathing ____ Thyroid Issues ____ Not Sleeping ____ Lower Back Pain ____

Sciatica ____ Fibromyalgia ____ Knee Pain _____ Other _____

By signing this form, I agree and consent to the Spinal Flow Wellness healing work.

I understand that with any healing process and work on my body, my symptoms may worsen before they get better.

I understand Spinal Flow Therapy is designed to assist the body with healing by helping to remove Physical, Chemical and Emotional stressors from my body. I understand that healing takes time and there is no quick or immediate fix to my ailment, pain or stressors, and overall health & wellness is a achieved over a period of time.

I have freely decided to undergo the recommended treatment and hereby give my full consent to the Spinal Flow Wellness therapist to perform treatment on me.

Client Name _____

Signature of Client_____Date:_____