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Please print clearly & legibly!!

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M/F DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Texting: Y N Weight:\_\_\_\_\_\_\_ Goal Weight:\_\_\_\_\_\_ Height:\_\_\_\_\_\_

Measurements: Waist: \_\_\_\_\_\_\_\_\_\_ Arms: \_\_\_\_\_\_\_\_\_\_\_ Legs: \_\_\_\_\_\_\_\_\_\_ Hips:\_\_\_\_\_\_\_\_\_ Neck: \_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My General Wellness is: \_\_Good \_\_Fair \_\_Poor How often can you commit to exercise per week \_\_\_\_\_

Hobbies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exercises you already do: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Chiropractic treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who can I thank for the referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diet: \_\_Good \_\_Fair \_\_Poor Water:\_\_\_\_

Sleep Habits: \_\_Good \_\_Fair \_\_Poor Stress Management: \_\_Good \_\_Fair \_\_Poor

What do you want to accomplish/goals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­

Health Information:

The information on this questionnaire will assist me with your massage as your therapist. All information is kept confidential. Please answer truthfully and circle all that apply:

Skin Rash Seizures Diabetes Bursitis

High/Low Blood Pressure Fainting Osteoporosis Numbness/Tingling

Heart Conditions Dizziness Whiplash Disk Problems

Chest Pain Lightheaded Stiff Neck Pain: \_\_\_\_\_\_\_\_\_\_\_

Phlebitis/ Blood Clots Asthma Headaches Sciatica

Bruise Easily COPD TMJ/Teeth Grinding Hip/Knee Replacement

Cancer: \_\_\_\_\_\_\_\_\_\_\_ Implants Trauma Y N Arthritis

Any Injuries, broken bones, or surgeries? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you want Medications: (prescription & nonprescription) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any pain with movement: Y N Have you seen a doctor for the pain? Y N Results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Allergies: (Oils, Nuts, Seeds, Medications, Etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Females: Are you Pregnant? Y N; If so how far long? \_\_\_\_\_\_\_\_\_ Are you considered high risk? Y N

Circle problem areas:

Front Back

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Kinetic Chain Checkpoint:** | **Anterior View** | **Posterior View** | **Lateral View** | **Additional Comments** |
| **Foot and Ankle** |  |  |  |  |
| **Knee** |  |  |  |  |
| **LPHC** |  |  |  |  |
| **Shoulder** |  |  |  |  |
| **Head and Neck** |  |  |  |  |

**Static Postural Assessment: Observations**

**Overhead Squat Assessment (OHSA)**

|  |  |  |  |
| --- | --- | --- | --- |
| View | Kinetic Chain Checkpoint | Observation | Notes |
| Left | Right | Left | Right |
| Anterior | Foot / Ankle | Feet turn out? | Y or N | Y or N | Y or N | Y or N |
| Knee | Knees moves in? | Y or N | Y or N | Y or N | Y or N |
| Lateral | Lumbo-pelvic-hip-complex | Excessive Forward lean? | Yes or No |
| Low back arches? | Yes or No |
| Shoulder | Arms fall forward? | Yes or No |

Single-Leg Squat Assessment

|  |  |  |  |
| --- | --- | --- | --- |
| View | Kinetic Chain Checkpoint | Observation | Notes |
| Anterior | Knee | Knees moves in? | Left | Right |
| Y or N | Y or N |
| Ankle | Ankle moves in or out? | Y or N | Y or N |
| Arms | Arms move out or down? | Y or N | Y or N |