Client Intake Form: Home Office

First Name: _____ **Last Name:**_____
Home Address:_____
Email: _____
Company Name:_____
Company Address:_____

What are the primary goals for assessment? (check all that apply)

- ☐ General office setup
- ☐ Posture and positional education
- ☐ Office Equipment Recommendations
- ☐ Guidance on remediating work-related pain
- ☐ Recommendations for stretches / exercises

How much time each day do you spend…

- Typing (Desktop): ____ hours/day
- Typing (Laptop): ____ hours/day
- Writing: ____ hours/day
- Using a tablet: ____ hours/day
- Using a phone: ____ hours/day
- Sitting: ____ hours/day
- Standing: ____ hours/day

- *TOTAL hours worked: Daily*_____, *Weekly:* _____

Do you exercise? (Yes) / (No) **If yes, how often?** _____

What pain, if any, you are experiencing with work:

Additional concerns / comments: