Client Intake Screen

Name _____ **Date**_____

Occupation		
Does your occupation require extended periods of sitting?	YES	NO
Does your occupation require repetitive movements? (If YES, please explain.) _____	YES	NO
Does your occupation require you to wear shoes with a heel (e.g., dress shoes)?	YES	NO
Does your occupation require heavy lifting?	YES	NO
Does your occupation cause you mental stress?	YES	NO

Lifestyle		
Do you have any stressors in your personal life? (If YES, please explain.) _____	YES	NO
Do you get 8 or more hours of sleep per night? (If NO, please explain.) _____	YES	NO
Do you feel energized throughout the day and prior to activities? (If NO, please explain.) _____	YES	NO
Do you believe you are drinking enough fluids?	YES	NO

Recreation		
Do you partake in any recreational physical activities (golf, skiing, etc.)? (If YES, please explain.) _____	YES	NO
Do you have any additional hobbies (reading, video games, etc.)? (If YES, please explain.) _____	YES	NO

Medical		
Have you ever had an injury to your ankles, knees, back, or shoulders? (If YES, please explain.) _____	YES	NO
Have you ever had any surgeries? (If YES, please explain.) _____	YES	NO