



CLIENT FORM

Please fill out this form if you are planning to participate with a client's treatment in the chamber.

Client name _____
(First) (Middle) (Last)

Birthdate _____ Age _____ Weight _____ Height _____
(M/D/Y)

Mailing Address _____
(Street) (Apt#/Box#)

(City) (State) (Zip Code)

(E-mail Address)

Home Phone _____ Business Phone _____ Fax _____

Primary physician _____ Phone _____

Clinic/hospital _____

Address _____
(Street)

(City) (State) (Zip Code)

Primary Diagnosis _____ Secondary Diagnosis _____

Describe Mobility _____

List current therapies _____ List current medications _____

List any allergies _____

