

# F&LC Assessment Form

Office code \_\_\_\_\_

DATE \_\_\_\_\_

Please circle: Mr Mrs Miss Ms Dr Other

Given Name \_\_\_\_\_ Surname \_\_\_\_\_

Preferred Name \_\_\_\_\_

Phone No: (H) \_\_\_\_\_ (M) \_\_\_\_\_ (W) \_\_\_\_\_

Address \_\_\_\_\_ P/C \_\_\_\_\_

Email \_\_\_\_\_

Occupation \_\_\_\_\_ Date of Birth \_\_\_\_\_

Do you have health insurance with extras? Yes No (please circle)

The name of the person responsible for account \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## How did you hear about us? (please circle)

Other client Newspaper Radio Website Saw Sign

Other: \_\_\_\_\_

## Reason(s) for consulting us (please circle)

Low Back Pain Weak Ankles Heel Pain Sore Shins

Knee Pain Hip pain Numbness/tingling in legs/feet

Cracking in joints Tired/Aching Feet or Legs

Other: \_\_\_\_\_

Which of the above is worse? \_\_\_\_\_

When at its worse, how does it feel? \_\_\_\_\_

Have you had this problem before? \_\_\_\_\_ If yes, for how long? \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

## What improvements are you seeking for your body? (please circle)

Freedom from orthotics More mobility Pain relief Overall wellbeing

Stronger muscles Preventative Care Improved balance Better joints

Other: \_\_\_\_\_

What would you like to achieve that you currently are unable to due to your problem? \_\_\_\_\_

\_\_\_\_\_