A B O U T Y O U

This evaluation form will help Sigrid understand some of your background and will save time during our session .
Please complete prior to your session (ideally at least 3 days before).

EVALUATION FORM

Name

_____ _____

First Name Last Name

Email Address

_____

Phone

_____

Current Physical Condition

Describe any current chronic or acute physical pain, discomfort, challenges or limitations you have:

Pain Medication

Do you take pain medication? If yes, what kind:

Activities

What kind of activities have you done a lot of in your life, past and present?

Exercise

Do you engage in regular exercise, and if yes, what kind?

Sitting

Does your work involve extended periods of sitting and computer work? Describe:

Accidents, Injuries or Surgeries

List any accidents, injuries, surgeries or other health problems/ approximate dates;

Things Making Your Condition Worse

Are there specify movements or activities that make things worse? Are symptoms worse at the beginning of the day day or end?

Sleep Position

What positions do you prefer to sleep in?

Aspirations

What would you like to do that you can't do right now. What are your goals?

This Work

How did you hear about me and / or this work?

Scoliosis; Questions Particular To Those With Scoliosis

(Please answer these questions only if you have a scoliosis condition, otherwise , skip)

When were you diagnosed with scoliosis?

MM DD YYYY

In what ways has scoliosis impacted your life?

Thank you

We respect your privacy. The information you provide is always confidential.