Egoscue Method Client Intake Form

Client: _____ Date: _____

Email: _____

Current Symptoms	Level 1-10
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____

Occupation: _____

Do you have any health issues?

_____

Are you currently on any pain or other medications?

_____

What position, if any, increases your pain?

_____

What position, if any, decreases your pain?

_____

Do you have trouble sleeping due to pain?

_____

What time of day do you have the most pain?

_____

Do you feel better or worse with movement?

_____

What kind of exercise or activities are you involved in?

_____

What is your primary reason for joining this program?

Short-Term Goal(s): _____

Long-Term Goal(s): _____

Time willing to invest in menu: _____

What time is best for your menu? AM PM Split Any Pre/Post

Type of Learner: Auditory Visual Kinesthetic

MY WELLNESS PROFILE

1. Daily Activities

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

1) Yes, limited a lot; 2) Yes, limited a little; 3) No, not limited at all

☐1	☐2	☐3	Lifting or carrying groceries (Check one.)
☐1	☐2	☐3	Moving a table, vacuuming (Check one.)
☐1	☐2	☐3	Climbing several flights of stairs (Check one.)
☐1	☐2	☐3	Walking several blocks (Check one.)

2. Exercise

How many days per week do you engage in aerobic exercise of at least 20 to 30 minutes in duration (brisk walking, cycling, jogging, swimming, aerobic dance, active sports, or gardening)? (Check one.)

No exercise programs
Two days a week
Three days a week
Four days a week
Five days a week
Six days a week
Seven days a week

3. Strength

How many times per week do you do strength-building exercises such as sit-ups, push-ups, or use strength training equipment? (Check one.)

None
Once a week
Twice a week
Three plus times weekly

4.Stretching

How many times per week do you do stretching exercises to improve flexibility of your back, neck, shoulders, and legs? (Check one.)

None
Once a week
Twice a week
Three plus times a week

5. Activities

Which activities do you prefer? (Check all that apply.)

Walking
Running
Bicycling
Canoeing
Surfing
Aerobics with Music
Dancing
Golf
Handball / Racquetball
Hiking / Backpacking
Calisthenics
Skating
Skiing - X country
Skiing - downhill
Stair Stepping
Swimming
Tennis
Weight training
Yard work / gardening
Active Sports
Volleyball
Baseball
Football
Triathlon

7. Dieting

Do you diet often, at least 1-2 times per year? (Check one.)

Yes
No

8. Hydration
How much water a day do you drink? (Check one.)

8 oz or less 9 oz - 24 oz 25 oz or more

9. Group activities
Do you participate in group workouts? (Check one.)

Yes
No
No - but I would like to

10. Training
Do you work out with a trainer? (Check one.)

Yes
No
No - but I would like to

11. Additional information
Aside from correcting your posture, is there health related information that you are interested in getting from Egoscue? (Check one.)

Yes
No

12. Posture
Have you been informed about your posture prior to coming to Egoscue? (Check one.)

Yes
No

13. Symptom
Have you seen a physician or other healthcare practitioner about your particular symptom(s)? (Check one.)

Yes
No

14. Symptom location
Where do you hurt? To the best of your ability please tell us the area closest to the symptom. (Check all that apply.)

Head and Neck
Shoulder Upper
Arm
Elbow
Forearm

Wrist and I-land
Chest
Stomach
Upper Back Lower
Back
Hip and pelvis
Thigh Front or Back
Knee
Ankle and foot
Nerve Pain down arm
Nerve Pain down leg
Dizziness or ringing in ears

15. Sleep
On average, how often do you get at least 7 - 8 hours of sleep each day? (Check one.)

Always or nearly always
Most of the time
Less than half of the time
Seldom or never

16. Do you smoke? (Check one.)

Yes
No

17. Stress (Check all that apply.)

Minor

Moderate

High

18. Medicine

Are you taking any medications? (Check one.)

Yes
No

19. Job description
Select description that best describes the kind of work you do. (Check one.)

Sales Office worker
Sales - Outside
Delivery / Driver
Health Professional

Manager / Professional
Technical
Service
Homemaker
Skilled craft / Trade
Agriculture / Laborer
Equipment
Operator
Factory Worker
Unemployed
Student
Retired
Professional Athlete
Clergy
Other

20. Doctor Visits
How many visits have you made during the past 12 months to a doctor, emergency room, psychiatrist, chiropractor, or other healthcare professional? (Check one.)

None
One
Two
Three
Four
Five
Six
Seven
Eight
Nine
Ten or more

21. Time
If needed, when is the best time to contact you? (Check one.)

Morning
Afternoon
Evening

22. Contact preference
Which mode of communication would you prefer to use for follow up conversations with a therapist? (Check one.)

Email
Phone
Both - email and phone