BODY STRESS RELEASE
Unlocking tension - Restoring self-healing

Client Stress Evaluation

Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City, State, Zip: _____ Email: _____

Do you experience any of the following?

N=Never; S=Sometimes; U=Usually (Please circle your response for each question.)

NECK:

Have you ever have a whiplash?	No / Yes
Neck stiffness / weakness / numbness?	N S U
Neck pain or aching?	N S U

HEAD:

Headaches	N S U
Migraines	N S U
Jaw Pain	N S U

BACK OR SHOULDERS

Shoulder pain / numbness?	N S U
Elbow pain / numbness?	N S U
Finger numbness / tingling?	N S U
Upper or mid-back pain?	N S U
Lower back pain / stiffness?	N S U

HIPS, LEGS, KNEES, FEET:

Pain in hip joints?	N S U
Leg or ankle numbness/pain?	N S U
Sciatic nerve pain?	N S U
Foot or toe numbness/pain?	N S U
Calf Cramps?	N S U

DIGESTIVE:

Indigestion or heartburn?	N S U
Diarrhea or constipation?	N S U

ADDITIONAL ITEMS:

1. Ever experience any severe falls? Details: _____
2. Operations? Details: _____
3. Fractures? Details: _____
4. Car / motorcycle accidents? Details: _____
   _____
5. Do you exercise regularly? Details: _____
6. Hours daily using computer? Details: _____
7. How would you describe your posture? Poor / Good / Excellent
8. Circle the level of pain you are currently feeling: None 1 2 3 4 5 6 7 8 9 10 Off the Chart