Egoscue Method® Client Intake Form

Client:_____ **Date:**_____

Current Symptoms **Level 1-10**
(please include severity on 0 to10 scale: 0 – no pain, 1-3 – mild, 4-6 – moderate, 7-9 – severe, 10 – disabling, the worst pain ever experienced by you)

1._____

2. _____

3. _____

4. _____

5. _____

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 favorite exercises (if any)?
_____
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 Activity

Type of Learner: Auditory Visual Kinesthetic