

Client Name: _____

Date: _____

Case #: _____



Client Needs Screen (CNS)

★ 1. Have you had a fall in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 2. Do you have a fear of falling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 3. Would you like your balance to be assessed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 4. Do you experience dizziness or imbalance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 5. Do you lose your balance when stepping up/down curbs or stairs/steps?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 6. Do you have a difficult time walking in the dark?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 7. Do you have difficulty hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 8. Do you have osteoporosis, osteoarthritis and/or joint pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 9. Do you take bone and/or joint supplements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 10. Do you experience muscle aches, pains and/or muscle cramping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 11. Do you use cold, heat or compression therapy at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 12. Are you interested in learning how compression clothing with ice could help your condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 13. Are you interested in learning how home heat and/or cold therapy could help your condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 14. Do you have foot and/or ankle pain/discomfort?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 15. Do you currently wear shoe inserts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 16. Are you interested in learning about how a shoe insert could help your condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 17. Do you have pain and/or physical challenges other than what you are being seen for today?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 18. Would you like to get more information about your whole body health?	<input type="checkbox"/> Yes <input type="checkbox"/> No
★ 19. Are you interested in learning how a medically based fitness program could safely optimize your physical condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No