INSPIRED BODY THERAPY, LLC
Patient History Form

NAME _____ **DATE** _____

ADDRESS_____

CITY_____**STATE**_____**ZIP**_____

PHONE _____ **CELL PHONE** _____

E-MAIL ADDRESS _____**DATE OF BIRTH** _____

REFERRING DOCTOR (if applicable) _____
PHONE NUMBER:_____

HOW DID YOU HEAR ABOUT US? _____

Are you currently under Workers Comp. or other insurance claim? _____
If yes, please explain:_____

MEDICAL HISTORY FORM and QUESTIONNAIRE

What is the primary problem(s) you would like your therapist to address?

_____

_____

_____

How long have you had the problem(s)? _____

What activities/ movements increase your pain?_____

_____

What things help decrease your pain?_____

What is your occupation? _____

Sports or other activities _____

Please rate your pain from 1 to 10, 1 being very little pain and 10 would take you to the emergency room. _____

Which of the following conditions are you currently being treated for or have been treated for in the past. (please check)

____ Headaches	____Concussions	____Numbness/tingling
_____Migraines	____ Emphysema	____Heart valve replacement
____ Latex Allergy	____ Fibromyalgia	____ Lyme disease
	____ Fractures	____ Motor Vehicle Accident
____ Arthritis	____ Heart Disease	____ Neuromuscular Disorder
____ Asthma	____ Heart Attack	____ Osteoporosis
____ Back Pain	____ Bowel Problems	____ Seizures/Convulsions
____ Bleeding Dis-	____ Hepatitis	____ Shortness of Breath
Orders	____Neck Pain	____ Stomach Ulcers
____ Cancer	____ High Blood Pressure	____ Stroke
____ Diabetes	____ Joint Replacement	____ Other:_____
____ Tuberculosis	____ TMJ pain	

Medical History: Please list all Surgeries and/ or Significant Injuries.

Please check any of the following that you may have or wear:
___Contacts ___ Dentures ___ Pacemaker ___Metal Object _____Implant
_____ Surgical Mesh _____Breast Implants _____Corneal transplants

Are you pregnant or trying to become pregnant? ___ Yes ___ No

Emergency contact name and number _____

What are your goals for therapy?_____
_____

To the best of my knowledge, the information provided herein is complete and correct. It is my responsibility to update the therapist on any changes. By signing this form I consent to treatment.

Signature _____ **Date** _____