PATIENT HISTORY FORM

Personal Information

Full Name: _____ Date of Birth: _____ Age: _____
Gender: MALE FEMALE *(MM/DD/YYYY)*

Address: _____
Street *City* *State* *Zip Code*

Phone Number: _____ Email: _____

Which do you prefer? TEXT CALL EMAIL

How did you hear about us? Event Facebook Instagram Website Newsletter
Family/ Friend (if so, who can we thank?) _____
Other: _____
What is your occupation? _____
Rate your health: EXCELLENT VERY GOOD GOOD FAIR POOR
Do you exercise? YES NO If yes, what do you do? _____

Why you're here

Main Complaint: _____

_____

_____

Pain levels the past week (0-10, 0 no pain, 10 Emergency room pain):
Lowest_____/10 Highest_____/10 Average_____/10
Your pain is: CONSTANT INTERMITTENT
When did this start? (*date of injury*) _____

What makes your pain/symptoms better? _____

What makes your pain/symptoms worse? _____

What can you *not do* because of your pain/symptoms? _____

What do **YOU WANT to get back to doing?** (multiple answers accepted)

_____

_____

_____

Important Sport or Activity return you are targeting a return to? (List date)

_____

_____

_____

PATIENT MEDICAL HISTORY FORM

Name: _____
Name of Referring Doctor: _____
Have you been to your primary care doctor for this injury: YES NO
Have you had **surgery** for *this* injury? YES NO
List any surgery(ies) you have had:
_____
List any allergies you have: _____
List any medications you currently are taking: (prescription and/or over the counter medicines)
_____
What treatments have you already tried for this condition (PT, Chiropractor, Injections, Surgeries, physician, etc)?
_____

_____

Do you now or have you ever had any of the following? (*check all that apply*)

____ Asthma, Bronchitis, or Emphysema
____ Anemia
____ Heart Disease/ Attack
____ High Cholesterol
____ Gout
____ Dizziness or Fainting
____ Anxiety
____ Depression
____ Joint Replacements
____ Severe or Frequent Headaches
____ Osteoporosis
____ Sleeping Problems/Difficulties
____ Blood Clot/Emboli
____ Pacemaker
____ Vascular/Circulation Problems
____ Unexplained Weight Loss/Energy Loss
____ High Blood Pressure
____ Shortness of Breath/Chest Pain
____ Diabetes
____ Thyroid Disease
____ Cancer
____ Rheumatoid Arthritis
____ Osteoarthritis
____ Bowel or Bladder Problems
____ Hernia
____ Stroke/TIA
____ Vision or Hearing Difficulties
____ Hepatitis
____ Epilepsy/Seizures
____ AIDS/HIV
____ Currently Pregnant
____ Do You Smoke?

If you marked yes to any of the above, or if not listed, please provide more information.

_____

What Tests (x-ray, CT scan, MRI, EMG) have you had recently? Please elaborate on date/findings.

_____

Please list any additional information that would assist us in providing care to you?

_____

_____

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Patient Signature:_____ Date:_____/_____/_____

Guardian Signature :_____ Date:_____/_____/_____

(if patient is under the age of 18)

Therapist Signature:_____ Date:_____/_____/_____

Body Rehab & Performance

INFORMED CONSENT: I understand that Body Rehab & Performance will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I do hereby agree and give my consent for Body Rehab & Performance to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

*Initial: _____

FINANCIAL RESPONSIBILITY: I understand that this clinic is not in network with any provider and I am 100% responsible for all financial obligations. At the end of my course of care I may receive a superbill upon request where I am able to submit the claims myself to my insurance provider. Body Rehab & Performance does not guarantee any reimbursement from your insurance provider.

*Initial: _____

24 Hour Cancellation Policy: Please provide 24-hour notice in order to reschedule or cancel your appointment. Note that your appointment time is reserved specifically for you; There are others that would like to reserve a spot as well and if you cancel, that takes time from them being able to get better.

*Initial: _____

Photo/Video Release: I grant Body Rehab & Performance the non-exclusive, non-royalty right to record myself, quotes, written statements, and/or voice on videotape, film, print, or any other media for promotional and marketing purposes.

*Initial: _____

By signing below, I have read the consent, financial responsibility,24 hour cancellation, and photo/video release policies above and agree to give my consent and understand my financial obligations,

Patient Signature:_____ Date:_____/_____/_____

Patient Name (printed):_____

Guardian Signature: _____ Date:_____/_____/_____
(if patient under 18)