



CONFIDENTIAL HISTORY FORM

Name: _____ Date ____ / ____ / ____

Address: _____

E-mail: _____ @ _____

Phone Number: _____ If referred, by whom? _____

Age: ____ Birth Date: ____ / ____ / ____ Height: ____ Weight: ____

Marital Status: M S D W How many children do you have? ____

Occupation: _____

Exercise and Energy Levels

Do you exercise? Y N How often? _____

What type of exercise do you do mostly? (cardiovascular, weight training, etc.)

Sleeping Habits

Do you sleep soundly at night? Y N
If not, explain: _____

Average number of hours you sleep: ____

Have you noticed there is a particular hour of the night that you wake up? ____
Do you have trouble falling asleep? _____

Medication Information

How often do you take aspirin, Advil or Tylenol? ____ / day OR ____ /week

Do you take any vitamin/mineral supplements or herbal supplements? Y N
Please list and describe what they are for: _____



Women:

Are you currently on any hormone replacement therapy? Y N

If yes, please explain: _____

Are you pregnant or is there a possibility that you are? Y N

Medical History

Do you have any known allergies/sensitivities to any foods, medications, airborne particles, etc.? _____

Have you ever been diagnosed with any type of tumor or cancer? Y N

If yes, please explain: _____

Have you ever undergone any surgeries? Please list with dates:

Please list any injuries or accidents you have been treated for, with dates:

Do you suffer from now or in the past five years any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chronic headaches |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Jaw Pain TMJ | <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Cold hands/feet |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Yeast infections |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Joint instability | <input type="checkbox"/> Difficult digestion | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Inguinal hernia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Other _____ | | |



Have you ever had problems with any of the following? (circle all that apply)

Brain Thyroid Heart Pancreas Liver Stomach Spleen
Small intestine Large intestine Colon Gall bladder Kidney Pituitary
Reproductive system Lymphatic system Adrenals

If you indicated any problems in the above question, please explain:

What is your chief complaint today? _____

How long have you had this condition? _____

How did this condition begin? _____

Is there pain involved with this condition? Y N

On a scale of 1 to 10, 10 being the most severe, how would you rank the pain involved in this condition? _____

Is there anything that makes this condition better? _____

Is there anything that makes this condition worse? _____

How would you describe this pain? (sharp, dull, achy, throbbing, etc.)

Is there any part of the day that your condition is better? _____

Is there any part of the day that your condition is worse? _____

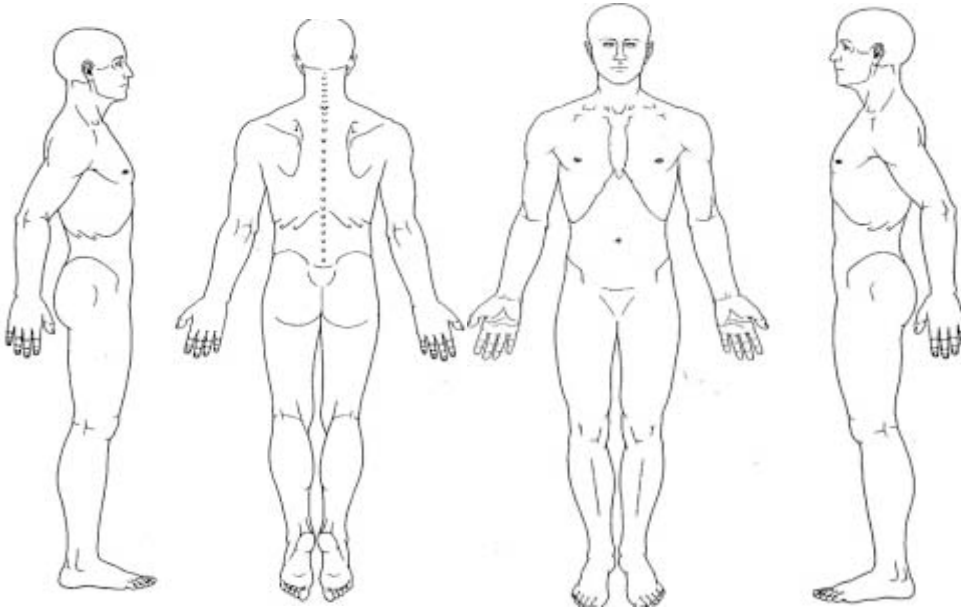
Has your condition been constant, or does it come and go? _____



Have you seen any other health care practitioner for this condition?

If so, who and when? _____

Please indicate the area of complaint (if applicable):



Performance Therapy, LLC

Is there anything you would like to add that was not covered in the information above?



**Performance Therapy. LLC
Terms of Acceptance**

I understand that Performance Therapy practitioners do not diagnose illness, disease, or other physical or mental disorders. Performance Therapy practitioners do not prescribe medical treatment or pharmaceuticals. It has been made clear to me that Performance Therapy is not a substitution for medical examination or diagnosis, and it is recommended that I see a physician for any physical ailment that I might have. I have stated all my known medical conditions, and I take it upon myself to keep the Performance Therapy practitioner updated on my physical health.

CONSENT TO TREAT A MINOR

Performance Therapy requires authorization to treat a minor in the absence of a parent or legal guardian.

Name of Minor _____ Date of Birth _____

Parent/Legal Guardian Signature _____ Date _____

Performance Therapy is a systematic approach towards successfully treating soft tissue structures, integrating the use of advanced soft tissue skills with functional strengthening techniques. Performance Therapy is specifically designed to assess the Kinetic Chain, locate and release adhesions, and restore proper muscle-contractual timing patterns. This method softens, stretches and releases the fibrous scar tissue, resulting in decreased restriction to circulation, increased range of motion and increased strength. This is not a massage. Sessions are based on clinical treatments. Sessions are not based on time nor are you charged by the amount of time it takes to complete a session. Time of sessions will vary depending on the problem and the individual. Sessions are booked in time periods (units) to help with patient flow. Session costs are \$40.00 per visit unless discussed otherwise. Performance Therapy requires that all payments are due when services are rendered. Performance Therapy accepts cash, checks, Visa, or MasterCard. There will be a \$25 fee for all returned checks. There will be a \$30 charge for any cancellations made within 24 hours of your appointment, excluding illness.

Print Name _____

Signature _____ Date _____