Charlotte Office
7215 Pineville-Matthews Road
Suite 100
Charlotte, NC 28226
Phone: 704.541.8655

Performance Therapy of Greenville
1 Caledon Court
Suite B
Greenville SC 29615
Phone: 864-233-4226

CONFIDENTIAL HISTORY FORM

Name: _____ **Date:** ____/____/____

Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

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, swimming, etc.)

_____

Sleeping Habits

Do you sleep soundly at night? Y N

If not, explain:

_____

_____

Average number of hours you sleep: _____ hrs

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 pregnant? 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:

( ) Low Blood Sugar	( ) Arthritis	( ) Chronic Headaches
( ) Ringing in the ears	( ) Asthma	( ) Heart Disease
( ) Jaw Pain TMJ	( ) Deep Vein Thrombosis	( ) Cold Hands/Feet
( ) Constipation	( ) Sinus Congestion	( ) Anemia
( ) Dry Skin	( ) Sciatica	( ) Tendonitis
( ) Fatigue	( ) Depression	( ) Yeast Infections
( ) High Cholesterol	( ) Carpal Tunnel	( ) Hemorrhoids
( ) Joint Instability	( ) Difficult Digestion	( ) Scoliosis
( ) Inguinal Hernia	( ) Stroke	( ) Nervousness
( ) High Blood Pressure	( ) Hepatitis A B C	( ) Tuberculosis

Other: _____

Medical History (continued)

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

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

If you indicated any problems above, please explain:

_____

_____

What is your chief complaint today?

_____

_____

How long have you had this condition?

_____

_____

How did this condition begin?

_____

_____

Is there pain involved in this condition? Y N

On a scale of 1 to 10, with 10 being the worst possible pain you can think of, how would you rate this pain? _____

Is there anything that will make this condition better?

_____

_____

Is there anything that will make this condition worse?

_____

_____

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

_____

_____

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

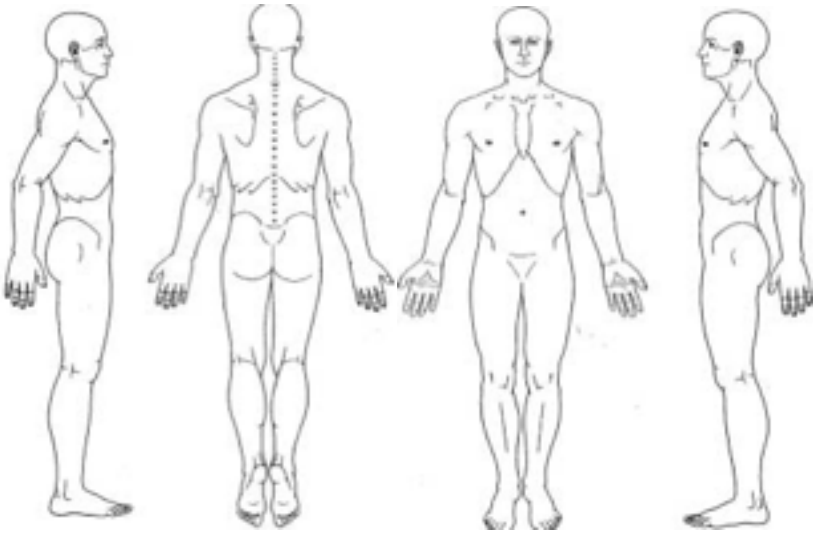
_____

Have you seen any other health care practitioner for this condition? If so, who and when?

_____

_____

Please circle the area of complaint (if applicable):



Performance Therapy, LLC

Is there anything you would like to add?

_____

_____

_____

_____

_____

_____

_____

_____

_____

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 that it is recommended that I see a physician for any physical aliment that I might have. I have stated all my known medical conditions and 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. New patient evaluation is $100.00. Follow up session costs are $50.00 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 charge of the full amount of the visit for any cancellations made within 24 hours of your appointment excluding illness.

Print Name _____

Signature _____

Date _____ / _____ / _____