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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:

- | | | |
|--|---|--|
| <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 | <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"/> Nervousness |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> 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?

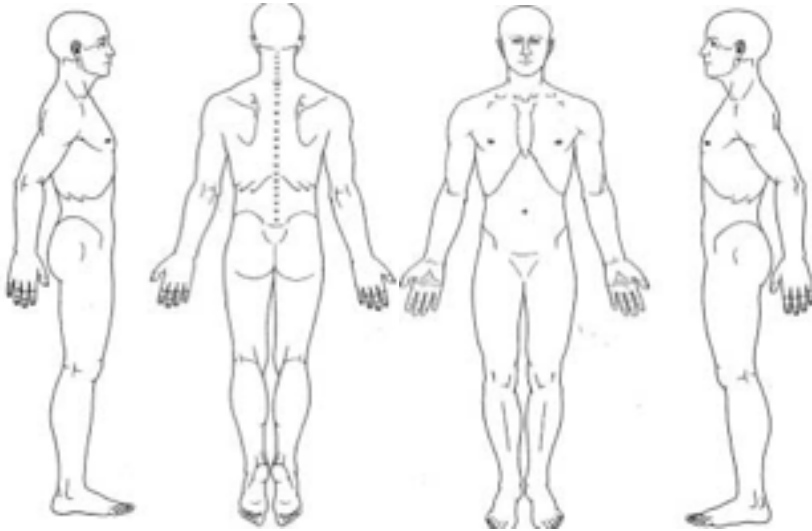
How would you describe this pain, if applicable? (sharp, dull, achy, throbbing, etc.)

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 ailment 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 \$65.00. Follow up session costs are \$45.00 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 ____ / ____ / ____