Inspiral Arts

Date_____
Patient DOB_____

A. Client Information

Patient Name _____ _____
Address_____
City_____ State _____Zip _____
Phone_____
Email_____
Occupation_____
Emergency contact_____
Phone_____
Physician/Care provider_____
Phone_____
Permission to consult Dr. Initials_____Date_____

Injuries _____
_____
_____
_____
Major illnesses _____
_____
_____
Emotional trauma _____
_____
Birth history _____
_____
_____

B. Current Health Information

Health concerns and expectations for treatment.

_____
_____
_____
Pain location and Intensity (0-10) _____
_____
_____
Constant or Intermittent ↑ or ↓ w/activity

Medications_____
_____
_____
Limited daily activities?
_____
_____

List self-care routines

How do you reduce stress?
_____
_____
Pain?_____
_____
Exercise?_____

C. Health History

List and explain including dates.
Surgeries _____
_____

Systems Check	**Current/Past/Family Hx**		
Nervous system			
Headaches/migraine			
Head injury/concussion #?			
Dizziness/vertigo			
Numbness, tingling			
Balance problems			
Paralysis			
Epilepsy			
ENT, ear, nose, throat			
Hearing loss			
Ringing in ears			
Ear tubes			
Vision loss			
Glaucoma			
Tonsillitis/removal			
Sinus issues/polyps			
Root canal			
Dental implant/Dentures			
Immune/Lymphatic			
Edema			
Inflammation			
Autoimmune disorders			

Cardiovascular			
Heart disease			
High/Low blood pressure			
Irregular hear beat			
Chest pain/ Shortness breath			
Blood clots			
Stroke			
Cold extremities			
Swollen ankles			
Varicose veins			
Cholesterol			
Respiratory			
Asthma			
Pneumonia			
Bronchitis			
Emphysema			
Allergies			
Cold/cough			
Musculoskeletal			
Rheumatoid arthritis			
Osteoarthritis			
Osteoporosis/Osteopenia			
Scoliosis			
Spinal problems			
Disk problems			
TMJ/Jaw pain			
Lupus			
Tendinitis/Bursitis			
Sprains/Strains			
Spasms/Cramps			
Stiff or Painful joints			
Weak or sore muscles			
Neck/Shoulder/Arm pain			
Low back/Hip/Leg pain			
Other:			
Skin: Athlete's foot/Warts			
Rashes/Eczema/Psoriasis			
Herpes			

Digestive/Elimination			
Abdominal pain			
Reflux			
Ulcers			
Gas/Bloating			
Food allergies			
Constipation/Diarrhea			
Bowel disease			
Liver disease/Gallstones			
Appetite/Nausea			
Bladder/Kidney			
Endocrine/Reproductive			
↓ Well being/↓Energy			
↓Mental clarity/Indecisive			
Delayed or Early puberty			
Female:Irregular menses/PMS			
Pregnancy # Births:			
Male: Loss of muscle/Weak			
Prostate			
General			
Sleep disturbances			
Infections			
Fever			
Cancer/Tumors			
Benign			
Malignant			
Habits			
Tobacco			
Alcohol			
Drugs			
Coffee/Soda			

Consent for Care

It is my choice to receive manual therapy and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my therapist of any changes in my health. Date_____

Signature:

_____