Patient Health Intake Form

MUSCLES IN MOTION

General Information

Name | Date of Birth | Age

Address

City | State | Zip Code

Phone # | Email

Is it ok to leave messages at this phone number? ☐ Yes ☐ No

Do we have your permission to contact you via the contact information provided on this form? ☐ Yes ☐ No

Emergency Contact Name | Phone #

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Latinx/Hispanic ☐ Native American ☐ Multi-racial

Birth sex: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to disclose

Gender: ☐ Female ☐ Male ☐ Non-binary ☐ Transgender ☐ Prefer not to disclose

Preferred pronouns

Family Information

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated ☐ _____

Spouse/Partner

Employment

Employer | Occupation

Please check all that apply:

- ☐ Disabled
- ☐ Employed Full Time
- ☐ Employed Part Time
- ☐ Retired
- ☐ Unemployed
- ☐ Student

Medical History

Please check all that apply:

- ☐ Aortic Aneurysm
- ☐ Anxiety
- ☐ Arnold-Chiari Malfomation
- ☐ Autoimmune Disorders
- ☐ Blood Clot Disorders
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes Type 1 or II
- ☐ Ehlers-Danlos Syndrome
- ☐ Fibromyalgia
- ☐ Headaches/Migraines
- ☐ Heart Disease
- ☐ Hepatitis B/C
- ☐ HIV
- ☐ Hypertension
- ☐ Lupus
- ☐ Lymphedema
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease

Medical History Continued

Surgical History: _____

_____

_____

Do you have any Implants? ☐ Silicone ☐ Pacemaker ☐ Injectable Fillers ☐ Hardware ☐ Spinal Stimulator

If yes, please explain location: _____

_____

What medications are you on?

_____

_____

_____

_____

Have you ever had Physical Therapy before? ☐ Yes ☐ No Did you have a positive experience? ☐ Yes ☐ No

Have you ever had Massage Therapy before? ☐ Yes ☐ No Did you have a positive experience? ☐ Yes ☐ No