AGAPE therapy REHAB RESTORE RECLAIM

ACCESS
MEDICAL HISTORY FORM

Level 1
Level 2

Name	Sex	Today's Date	Birthdate	Emergency Contact and Phone #
Address	Email		Cell Phone	Employer: Duty: ___ PT ___ FT
Doctor Name Doctor Location	**Is this condition**: *1. Fall related?* yes no *2. Automobile related?* yes no *3. Work related?* yes no			**Have you had therapy anywhere this year?** yes no # of visits _____ **Are you getting in home care?** yes no
How do you learn best? seeing doing hearing			**Do you have difficulty:** hearing seeing speaking reading	
How did you hear about us? (circle) Doctor order TV Commercials Drive by Been here before Friend Other:				

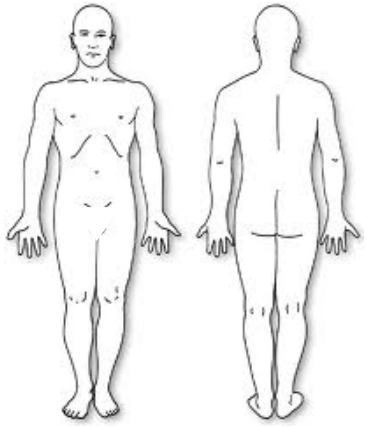
-IN REGARD TO CURRENT CONDITION/ISSUE-

Be specific, what is your chief complaint, include symptoms?

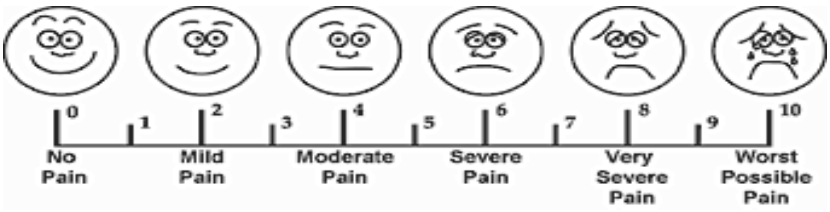
Is this the first episode? no yes If no, when was the first episode?

Symptoms since (date): **Symptoms (circle):** intermittent constant | getting better worse no change

Where is your pain? Mark on the person where your pain is and note type of pain.



Pain Intensity: ____/10 current _____/10 at best _____/10 at worst



Pain gets better with:
bending sitting turning rising standing walking lying AM PM as day progresses when still moving other

Pain gets worse with:
bending sitting turning rising standing walking lying AM PM as day progresses when still moving other

What is limited because of chief complaint: sleep self care housework reaching pushing pulling lifting carrying sitting standing bending squatting walking community access other

Sleep position: back belly right side left side recliner restless other:

Any other notes:

It's your choice where you get therapy, thank you for choosing Agape!

-MEDICAL HISTORY-

(Please fully answer these questions; you would be surprised how this helps us to help you!)

Please list and describe any injuries/falls/accidents/traumatic experiences, including past.

1.
2.
3.

Please list ALL…			
	Describe	When	Did it help?
Surgeries			
Injection(s)			
Any Imaging:	Xray CT Scan MRI Other:		
Other practitioners: (list)			
Other			

Medical History/Diagnosis(s)				
	When	Describe	Is it managed?	Any lasting effects?
Cancer				
Diabetes I or II				
Cardiovascular				
Respiratory				
Vascular(Strokes, etc)				
Infectious disease(s)				
Hepatitis				
Arthritis				
Other:				

List any allergies: **Do you carry**?: inhaler epi pen other:

Family History in regard to current condition:

What *Relationship to patient*

List current Medications/Vitamins/Supplements:

Name *Purpose*

Health Considerations: *Smoking*: currently _____ history _____

Alcohol: currently _____ history _____ rarely ___ a few times/month ____ everyday ____

Pregnancy: currently _____, # of weeks along _____ # of total pregnancies _____

Are you having issues with (circle):

changes in bowel/bladder	unexplained weight loss	symptoms with cough/sneeze
difficulty swallowing	ringing ears	dizziness
nauseous	always hot or cold	mood changes
skin changes	extreme fatigue	passing out
foggy mind	other :	

To the best of my ability, I have included all pertinent medical information. I also give consent to receive therapy by qualified staff and/or participate in fitness or physical activity opportunities.

Patient/Guardian Signature: _____ Date: _____

-Agape thanks you for your completeness; we promise it will help give you great care!

-LIFESTYLE FORM-

(NOTE: Answers on a 10 point scale mean, 1 being low/not good and 10 being high/very good)

Physical

Do you have trouble with daily activities or otherwise? yes no If so what?
What stops you from being active?

_____

Are you physically active, beyond daily activities? yes no If yes frequency/duration/intensity:
What do activities include?

_____

Would you like us to help you take steps to a healthier physical you? yes no

Stress

Do you prefer order and consistency_____ or look forward to change and surprises_____?
Do you feel: overwhelmed with life _____ in control_____ just getting by_____
How stressed are you on average?
1 2 3 4 5 6 7 8 9 10
What triggers stress for you?

_____

Do you practice stress-relieving efforts? yes no If yes, what

_____

Would you allow us to help you take steps toward a healthier balance of stress? yes no

Sleep

Do you get a full night's sleep most nights of the week? yes no Is it restful? yes no
What keeps you up? _____
Do you nap? yes no How do you feel when you wake up?_____
Do you have ways to prepare yourself for sleep? If so what_____
Would you like sleep to be better? yes no
Would you allow us to help you take steps toward better sleep? yes no

Nutrition

Overall your nutrition habits are 1 2 3 4 5 6 7 8 9 10
What nutrition habits do you do well?

_____

What nutrition habits could you do better?

_____

Are you happy with how your body looks and works for you?

_____

Do you understand the immense importance of nutrition and the function of your mind and body? yes no
What are barriers to you having healthy and appropriate nutrition?_____
Would you allow us to help you take steps towards better nutrition? yes no
Would you like a free initial nutrition consultation? yes no
How much percentage of your nutrition is from processed food?
10 20 30 40 50 60 70 80 90 100%

Emotional

How do you feel you manage your emotions?
1 2 3 4 5 6 7 8 9 10
Could you manage them better? yes no
How much do you believe your emotions affect the way you function day to day?
1 2 3 4 5 6 7 8 9 10
Do you believe an improper management of emotions can cause pain? yes no
Are there emotions that you tend to struggle with?

_____

What have you done to work on this?

_____

Would you be willing to let us help you take steps to a more healthy emotional you? yes no

Mental

Please mention any particular mental concerns/frustrations you manage for yourself?

_____

Are you happy with your thinking process? yes no

How much trouble do you have with memory? rarely every day more than I'd like short term long term

Do you have trouble reading?

_____

___

Do you have trouble comprehending new information?

_____

Is there anything you struggle with that you would be willing to let us help you with? no yes, what?_____

Spiritual

How important is the spiritual dimension of life to you currently?

1 2 3 4 5 6 7 8 9 10

Do you wish that to be different? yes no How?

What are things you do to enhance your spiritual life?

Would you allow us to help you take steps to enhance your spiritual life? yes no

Occupational

Job type/name : Work status: Full time____ Part time____ Other_____

Main work tasks: Sitting____ % Standing_____% Lifting_____% Repetitive motion (explain)_____

How well do you balance work with the rest of life

1 2 3 4 5 6 7 8 9 10

How invested do you feel in your job?

1 2 3 4 5 6 7 8 9 10

How thankful are you for your job?

1 2 3 4 5 6 7 8 9 10

Are there any skills/techniques/education that could help you make your job better?

Is there another job you would like to try? no yes

_____

How ready are you to take steps to try the new job?

1 2 3 4 5 6 7 8 9 10

Relationships

Do you have support of any family or friends? yes no

Mark the traits that would represent you most of the time?

Introvert Extrovert Listener Doer Helper Manager Healer Comedian Intuitive Decisive Indecisive Procrastinator Shy Depressed Angry Happy Relaxed Determined Comforter Protector Counselor Facilitator Creative Intellectual Fighter Arguer Meek Emotional Mood swings Pessimist Optimist Fixer Planner Spontaneous Resilient

Would you like to have help figuring out more about yourself and your nature? yes no

Would you like to learn how to be better in relationships? yes no

In particular: communication trusting mending relationships finding enjoyment again intimacy other

Would you be willing to allow us to help you take steps towards gaining skills for better relationships? yes no

What are your goals for your program with us?

Short Term	***Long Term***
1.	1.
2.	2.

Anything else you would like to share or ask about?

We thank for allowing us to help you on this journey! The greatest compliment we can get from you is a referral from you to a friend/family.

Release and Waiver of Liability

In consideration of my use of the exercise equipment and facilities provided by Agape Therapy and it's sites, I expressly agree and contract, on behalf of myself, my heirs, executors, administrators, successors and assigns, that the company and its insurers, employees, officers, directors, and associates, shall not be liable for any damages arising from personal injuries (including death) sustained by me, on, or about the premises, or as a result of the use of the equipment or facilities, regardless of whether such injuries result, in whole or in part, from the negligence of the company. By the execution of this agreement, I accept and assume full responsibility for any and all injuries, damages (both economic and non-economic), and losses of any type, which may occur, and I hereby fully and forever release and discharge the company, its insurers, employees, officers, directors, and associates, from any and all claims, demands, damages, rights of action, or causes of action, present or future, whether the same be known or unknown, anticipated, or unanticipated, resulting from or arising out the use of said equipment and facilities.

I expressly agree to indemnify and hold the company harmless against any and all claims, demands, damages, rights of action, or causes of action, of any person or entity, that may arise from injuries or damages sustained by me or my guest.

I agree to be solely responsible for safety and well being of myself. I understand that the company does not provide supervision, instruction, or assistance for the use of the facilities and equipment during non-staffed hours.

I agree to comply with all rules imposed by the company regarding the use of the facilities and equipment. I agree to conduct myself in a controlled and reasonable manner at all times, and to refrain from using any equipment in a manner inconsistent with its intended design and purpose.

I understand and acknowledge that the use of exercise equipment involves risk of serious injury, including permanent disability and death.

I understand and agree that the company is not responsible for property that is lost, stolen, or damaged while in, on, or about the premises.

I understand and agree that my use of the facilities and equipment is only to be undertaken on my own personal time, and that my use of the facilities and equipment is not within the course or scope of my employment.

I HAVE READ THE FOREGOING WAIVER AND RELEASE OF LIABILITY AND VOLUNTARILY EXECUTED THIS DOCUMENT WITH FULL KNOWLEDGE OF ITS CONTENT.

Signature:_____ Date:_____

Printed Name:_____

It is highly recommended that you consult your physician before engaging in a new fitness program