Michele Ruppert Rehabilitation Therapy
http://www.micheleruppert.com/
Confidential Client Information Form (rev 11/5/23)

Name: ______________________________ Date: ______________

Full Address: ____

Phone: Home: ______________ Work: ______________ Mobile: ______________

Date of Birth: ______________ Occupation: ______________________

Referred by: ______________ Email Address: ______________________

Confidential Health History

Are you **currently** under medical care or taking any medications, including blood thinner medications. If so, what?

____

____

____

____

Please provide additional information as necessary (approximate dates, frequency, etc.) to clarify the condition(s) from items checked on the next page.

____

____

____

____

List any other present and past accidents, injuries, major illnesses, hospitalizations, surgeries, etc. that has not been identified. Provide additional details as necessary.

____

____

____

____

Do you have any sensitive areas (i.e. ticklish, numbness over scars) that could affect your session? If so, what?

____

____

____

____

To the best of my knowledge I have accurately disclosed my present and past health conditions. This information will be kept in confidence and is vial to the appropriateness of the sessions designed by Michele Ruppert. I agree to inform Michele Ruppert if any concerns arise during the session. I understand that these rehabilitation therapy sessions are not intended as medical treatments and/or psychological treatments.

Signature: ______________________________ Date: ______________

Michele Ruppert Rehabilitation Therapy
http://www.micheleruppert.com/
Confidential Health History (rev 11/5/23)

Check the following conditions that apply to you, past and present. Please provide additional information as necessary to the backside of this document to clarify the condition.

Musculo-Skeletal
- o Headaches
- o Joint stiffness/swelling
- o Spasms/cramps
- o Broken/fractured bones
- o Strains/sprains
- o Back, hip pain
- o Shoulder, neck, arm, hand pain
- o Leg, foot pain
- o Chest, ribs, abdominal pain
- o Problems walking
- o Jaw pain/TMJ
- o Tendinitis
- o Bursitis
- o Arthritis
- o Osteoporosis
- o Scoliosis
- o Bone or joint disease
- o Gout
- o Other: ____________________

Circulatory and Respiratory
- o Dizziness
- o Shortness of breath
- o Fainting
- o Cold feet or hands
- o Cold sweats
- o Swollen ankles
- o Pressure sores
- o Varicose veins
- o Blood clots
- o Stroke
- o Heart condition
- o Allergies
- o Sinus problems
- o Asthma
- o High blood pressure
- o Low blood pressure
- o Lymphedema
- o Other: ____________________

Skin
- o Rashes
- o Allergies
- o Athlete's Foot
- o Warts
- o Moles
- o Acne
- o Cosmetic surgery
- o Other: ____________________

Digestive
- o Nervous stomach
- o Indigestion
- o Constipation
- o Intestinal gas/bloating
- o Diarrhea
- o Diverticulitis
- o Irritable bowel syndrome
- o Crohn's Disease
- o Colitis
- o Adaptive aids
- o Other: ____________________

Nervous System
- o Numbness/tingling
- o Twitching of face
- o Fatigue
- o Chronic pain
- o Sleep disorders
- o Ulcers
- o Paralysis
- o Herpes/shingles
- o Cerebral Palsy
- o Epilepsy
- o Chronic Fatigue Syndrome
- o Multiple Sclerosis
- o Muscular Dystrophy
- o Parkinson's disease
- o Spinal cord injury
- o Other: ____________________

For clients who need mobility assistance, please give your height: ________ weight: ________

Reproductive System
- o Pregnancy:
  - o Current
  - o Previous
- o Menstrual cycle problems
- o PMS
- o Menopause
- o Pelvic Inflammatory Disease
- o Endometriosis
- o Hysterectomy
- o Fertility concerns
- o Prostate problems

Other
- o Loss of appetite
- o Forgetfulness
- o Confusion
- o Depression
- o Hopelessness
- o Anxiety and Tension
- o Difficulty concentrating
- o Drug use __________________
- o Alcohol use _______________
- o Nicotine use _______________
- o Caffeine use _______________
- o Hearing impaired
- o Visually impaired
- o Burning upon urination
- o Bladder infection
- o Eating disorder
- o Diabetes
- o Hypoglycemia
- o Hypo/Hyper Thyroidism
- o Fibromyalgia
- o Post/Polio Syndrome
- o Cancer
- o Infectious disease (please list) ____________________________
- o Other congenital or acquired disabilities (please list) _______ ____________________________
- o Other: ____________________