InspireMe360 – Complete Body Medical History Form

Personal Information

Full Name:	
Date of Birth:	
Gender:	
Phone Number:	
Email Address:	
Emergency Contact Name:	
Emergency Contact Phone:	
Relationship to Emergency Contact:	

Medical Conditions (Check all that apply)

■ Heart Disease	■ High Blood Pressure	■ Low Blood Pressure	■ Stroke
■ Diabetes (Type 1 / Type 2)	■ Cancer	■ Asthma	■ COPD
■ Epilepsy/Seizures	■ Kidney Disease	■ Liver Disease	■ Thyroid Disorders
■ Arthritis	■ Osteoporosis	■ Autoimmune Disorders	■ Chronic Pain
■ Anxiety	■ Depression	■ PTSD	■ Other Mental Health Conditions

Allergies (Please list all food, drug, and environmental allergies)

Surgeries & Hospitalizations (Please include dates)

Current Medications (Include dosage & frequency)

Lifestyle Information

Do you smoke? ■ Yes ■ No	If yes, how many per day? _____
Do you drink alcohol? ■ Yes ■ No	If yes, how often? _____
Do you exercise regularly? ■ Yes ■ No	If yes, type & frequency: _____

Consent & Signature

I hereby declare that the information provided above is accurate and complete to the best of my knowledge. I understand that this information will be used to ensure my safety and well-being during my participation in InspireMe360 programs.

Signature:		Date:	