360 NEUROMUSCULAR THERAPY
CONFIDENTIAL MEDICAL HISTORY FORM

Name.....**Phone (Home)** .....

Address.....**Phone (Work)**.....

City ..... **State**..... **Zip**..... **Phone (Cell)** ..... m☐/f☐

Occupation..... **Date of Birth** ..... **Email** .....

How did you hear about 360NMT? .....

SECTION 1 **CURRENT / PAST MEDICAL CONDITIONS** *(place an **X** in the box to the right of each known condition)*

Head / neck	X	***Shoulder / arm***	X	***Back / pelvis / legs***	X	***General***	X
Headache/ migraine		Rotator cuff syndrome		Spinal deformity		Epilepsy / seizures	
Sinus pain		Pain between scapulae		Back pain / surgery		Anemia	
Facial (Bell's) palsy		Shoulder injury (surgery)		Sacroiliac dysfunction		Atherosclerosis	
Facial neuralgia		Frozen shoulder		Sciatic pain		Easy bruising	
Whiplash / MVA		Carpal tunnel syndrome		Groin pain		Blood clots	
Concussion, falls		Tennis elbow		Hernia		Skin sensitivities	
Broken neck		Golfer's elbow		Hip pain		Skin diseases	
Torticollis		Fractures: arm, wrist		Knee trauma		Malignancy/cancer	
Shooting pain in neck		Ligament sprains		Ankle trauma		Low blood pressure	
Hypothyroidism		Dupuytren's contracture		Foot pain / surgery		High blood pressure	
Other endocrine		Pins and needles		Varicose veins, phlebitis		Osteoarthritis	
Jaw pain or click		Cold hands (Raynaud's)		Night cramps, RLS		Rheumatoid arthritis	
Bruxism, grinding		Arthritis		Poor circulation		Joint stiffness	
Teeth, gum disease		***Chest and abdomen***		Clumsiness, trips or falls		Hypermobility	
Glasses/contact lens		Chest tightness		Flat feet		Diabetes	
Eye strain		Chest pain		***Mostly Female***		Abscesses / sores	
Light sensitivities		Heart disease		Pregnant		Weight loss / gain	
Loss of taste / smell		Rheumatic fever		Recently post-partum		Mental illness	
Recurrent colds / flu		Arteriosclerosis		IUD		Stress at work	
Hayfever / allergies		Indigestion		Osteopenia/porosis		Stress at home	
Stroke / TIA / AVM		Stomach cramps		Painful breasts		Anxiety / nervousness	
Poor balance		GERD/reflux/heartburn		Lymph node biopsy		Anger / fear / grief	
Dizziness / vertigo		Crohn's disease		Mastectomy/lumpectomy		Depression	
Fainting		Cœliac's disease		PID, IC, other pelvic floor		Fibromyalgia	
Deafness		Ulcers		Dys / amenorrhea		Mental fogginess	
Ringing in the ear		Irritable bowel synd.		Uterine abnormalities		Myofascial pain	
Thoracic inlet syndrome		Constipation		Urinary incontinence		Chronic Fatigue Syndrome	
Cervical rib		Loose bowel		Painful intercourse		Fatigue in general	
Recurrent sore throat		***Breathing***		***Mostly Male***		Malaise	
Tight throat		Shortness of breath		Testicular / groin pain		HIV / AIDS / TB	
Difficulty swallowing		Hyperventilation		Painful / frequent urination		Poor immune system	
Speech impediment		Asthma		Bladder disease (I.C.)		Excess perspiration	
Neck Surgery		Sighing, yawning, holding		Prostate problems		Altered sensations	

Other not listed: .....

Family history of:.....

Current medical diagnoses:.....

Emergency contact:..... Phone: .....

Therapist notes:.....

.....

SECTION 2 **HABITS OF DAILY LIVING**

(*please add an* ***X*** *to the right of just* ***one word per line*** *which best describes you*)

									Comments
Tobacco	Yes		No		Former				
Alcohol	Daily		Social		Weekend		None		
Coffee / tea	> 5 cups / day		2-5 cups/ day		1-2 cups / day		None		
Sugar / candy	Daily		Now and then		Binge		Seldom		
Fluid intake	8+ glasses/day		4 glasses/day		2 glasses/day		None		
Soda drinks	Daily		Now and then		Binge		Seldom		
Fast food	Daily		Now and then		Binge		Seldom		
Exercise	Daily		Regularly		Sometimes		Never		
Relaxation	Reading etc.		Meditation		Hobby		None		
Sleep	Deep long		Deep short		Fitful / Light		Insomnia		
Daily activities	Sitting		Standing		Up & down		Lying around		
Work activities	Repetition		Driving		Lifting, physical		Awkward, static		

Optional data: ..... Height.....inches Weight..... pounds

How do you rate your health in general? (*circle one*) 1. excellent 2. good 3. fair 4. poor 5. unhealthy

Notes:.....

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SECTION 3 **RELEVANT TRAUMA (Accidents / Fractures / Surgeries / Scars / Dentistry)**

(*list from most recent at the top and include dates, or year, and outcome if possible)*

Date: ..... Description: .....

Date: ..... Description: .....

Date: ..... Description: .....

Date: ..... Description: .....

Date: ..... Description: .....

Date: ..... Description: .....

Notes:.....

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SECTION 4 **HEALTH PROFESSIONALS ALREADY CONSULTED?** *(list in date order, the most recent first)*

Date: ..... Person: ..... Tel:..... Result:.....

Date: ..... Person: ..... Tel:..... Result:.....

Date: ..... Person: ..... Tel:..... Result:.....

Date: ..... Person: ..... Tel:..... Result:.....

Personal Physician / Case Manager: ..... Tel:.....

Results of last blood work:.....

Known deficiencies / insufficiencies: .....

Notes:.....

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SECTION 5 **CURRENT AND PAST MEDICAL PROCEDURES?**

Date: ..... Condition: ..... Procedure:.....

Date: ..... Condition: ..... Procedure:.....

Date: ..... Condition: ..... Procedure:.....

Date: ..... Condition: ..... Procedure:.....

Date: ..... Condition: ..... Procedure:.....

Notes:.....

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SECTION 6 CURRENT MEDICATIONS &/or SUPPLEMENTS?

Taking ..... for ..... Taking ..... for .....

Taking ..... for ..... Taking ..... for .....

Taking ..... for ..... Taking ..... for .....

Taking ..... for ..... Taking ..... for .....

Taking ..... for ..... Taking ..... for .....

Notes: .....

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SECTION 7 COLLECTION OF INFORMATION ON PAIN & DYSFUNCTION

What diagnoses do you have? .....

What is the main reason for your visit? .....

Is the main problem: 1. getting worse? 2. getting better? 3. staying the same? (*circle one*)

What makes it worse? .....

What makes it better? .....

What other symptoms do you have? .....

What activities can't you do? .....

What would you like to achieve from NMT? .....

Describe any other concerns you may have? .....

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Notes: .....

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Rating 1. **Today's pain intensity rating:** *(mark with a cross on the line)*

0 ____ 1_____ 2 ____ 3_____ 4 ____ 5_____ 6 _____7_____ 8 _____9 ____ 10

NO PAIN **MODERATE PAIN** **WORST PAIN**

Rating 2. **Today's subjective pain assessment rating:** *(mark with a cross on the line)*

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5

NO PAIN	MILD	DISCOMFORTING	DISTRESSING	INTENSE	EXCRUCIATING
	Annoying	Troublesome	Miserable	Dreadful	Unbearable
	Nagging	Nauseating	Agonizing	Horrible	Torturing
	Aching	Grueling	Gnawing	Vicious	Crushing
		Numbing	Throbbing	Cramping	Tearing

Rating 3. **Today's function rating:** (ability to shop, cook, clean, walk, climb stairs, drive, work, play, socialize)
(mark with a cross on the line)

0 ____ 1_____ 2 ____ 3_____ 4 ____ 5_____ 6 _____7_____ 8 _____9 ____ 10

FULLY ACTIVE **MODERATE** **LIMITED FUNCTION** **FULL IMPAIRMENT**

Rating 4. If, when your problem was at its worst it was 10/10, what is it now out of 10? ____ /10

Notes: .....

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SECTION 8 INFORMED CONSENT AND CANCELATION POLICY

I recognize that neuromuscular and therapeutic massage as well as acupuncture services can be legally provided in Massachusetts without referral from a physician. By signing this document, I assume all risk for my health and wellbeing, and hold harmless any responsibility 360 NeuroMuscular Therapy LLC or any persons involved in this program.

I hold harmless and agree to indemnify 360 NeuroMuscular Therapy LLC, its agents, servants, employees from any claims, damages, losses, expenses, costs and liabilities arising from the delivery and receipt of services from the company other than that which is due to the gross negligence or willful misconduct of its agents, servants and/or employees.

I have discussed my own physical limitations and/or suspected health concerns with 360 NeuroMuscular Therapy LLC staff.

- ✓ The confidential information contained on these pages and the daily intake forms belongs to me and are securely stored at 360 NeuroMuscular Therapy.
- ✓ Treatment will follow my informed consent and I can refuse aspects of the treatment at any time.
- ✓ I am aware of all prices per treatment and accept responsibility for payment in full at the conclusion of each session.
- ✓ I agree to give a 24-hour cancellation notification (emergencies excepted). I may be charged a $50 cancellation fee if 360 NeuroMuscular Therapy is unable to fill the appointment within that 24-hours..
- ✓ A completely missed appointment (no-show), without prior notice, will incur the full treatment fee.

Signature _____ **Printed name** _____

Parent / Guardian's signature if under the age of 18 _____

Signees relationship _____ **Date** _____ / ____/____

SECTION 9 AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION (If needed)

I, _____ hereby authorize 360 NeuroMuscular Therapy, LLC to discuss my treatment and disclose my massage therapy records to the following health providers:

_____

_____

_____

_____

I understand that I may revoke this authorization at any time, but that I may not hold 360 NeuroMuscular Therapy, LLC responsible for acting in a reasonable reliance on this statement prior to the time that it learns of my revocation. I understand that this authorization expires one year after the date signed below, unless I inform 360 NeuroMuscular Therapy, LLC otherwise.

_____ _____

Signature of Client (or legal representative) **Relationship to client**

_____ _____

Client name (printed) **Date**