360 NEUROMUSCULAR THERAPY
SHORT 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 360 NMT?.....

Main Reason For Your Visit:.....

Onset date and progression: .....

Site(s) of local / referred pain: .....

Is the main problem: Getting worse? Getting better? Staying the same? (*circle one*)

What makes it worse? .....

What makes it better?.....

Other concerns: .....

General health history: .....

Family history of:.....

Dietary habits:.....

Exercise habits: .....

Prior experience of bodywork:.....

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

Health Professionals Already Consulted: *(list in date order, the most recent first)*

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

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

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

Prior Relevant Trauma / Accidents / Surgeries / Dental Surgeries: *(list in date order, the most recent first)*

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

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

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

Current Medications &/or Supplements:

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

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

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

Therapist notes:.....

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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-hours cancellation notification (emergencies excepted), or I may be charged $50 cancellation if 360 NMT can't fill the appointment.
- ✓ A completely missed appointment, without prior notice, will incur the full treatment price.

Signature _____ **Printed name** _____

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

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

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:

_____

_____

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_____

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**