360 NEUROMUSCULAR THERAPY CONFIDENTIAL MEDICAL HISTORY FORM

2
(DEC)
NEURO MUSCULAR THERAPY
NEURO MUSCULAR THERAPY

Name		Phone (Home)	NEURO MUSCULAR THERA	
Address		Phone (Work).		NEUROTHUSCULARTHERAPY
City	State	Zip	Phone (Cell)	Male/female
Occupation		Date of Birth	ı Email	
How did you hear a	bout 360NMT?			

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

Head / neck	Х	Shoulder / arm	Χ	Back / pelvis / legs	Х	General	Х
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	
Thyroid problems		Sighing, yawning, holding		Prostate problems		Altered sensations	

Other not listed:
Family history of:
Current medical diagnoses:
Therapist notes:
·

Tobacco

Alcohol

HABITS OF DAILY LIVING

Yes

Daily

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

Former

Weekend

None

Comments

No

Social

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 Work activities	Sitting Repetition	Standing Driving	Up & down Lifting, physical	Lying around 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: 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:						
		SIONALS ALREADY				
Date:	Person:		Tel:	Result:		
Date:	Person:		Tel:	Result:		
Date:	Person:		Tel:	Result:		
Date:	Date:					
Personal Physician / Case Manager:Tel:						
Results of last blood work:						
Known deficiencies / insufficiencies:						
Notes:						
SECTION 5 CURRENT AND PAST MEDICAL PROCEDURES?						
Date:	Condition:		Procedure:			
Date:	Condition:		Procedure:			

 Date:
 Procedure:

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hat diagnoses do you have?							
the main reason for your visit?	ECTION 7	COLLECTION	OF INFO	RMATION ON PA	AIN & DYSFUNCT	<u> ION</u>	
the main problem: 1. getting worse? 2. getting better? 3. staying the same? (circle one) hat makes it worse? hat makes it better? hat other symptoms do you have? hat would you like to achieve from NMT? escribe any other concerns you may have? Dies: Today's pain intensity rating: (mark with a cross on the line) O12345678910 NO PAIN MODERATE PAIN WORST PAIN Today's subjective pain assessment rating: (mark with a cross on the line) O12345 NO PAIN MILD DISCOMFORTING DISTRESSING INTENSE Nagging Nauseating Agonizing Horrible Torturing Cramping Troublesome Miserable Dreadful Unbearable Nagging Nauseating Agonizing Horrible Torturing Cramping Throbbing Throbbing Cramping Tearing Today's function rating: (ability to shop, cook, clean, walk, climb stairs, drive, work, play, socializ (mark with a cross on the line) O12345678910 FULLY ACTIVE MODERATE LIMITED FUNCTION FULL IMPAIRMENT	/hat diagnoses	s do you have?					
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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 DISCLO	SURE OF MEDICAL INFORMATION (If needed)
I,h my treatment and disclose my massage therapy r	hereby authorize 360 NeuroMuscular Therapy, LLC to discuss records to the following health providers:
Therapy, LLC responsible for acting in a reasonal	at any time, but that I may not hold 360 NeuroMuscular ble reliance on this statement prior to the time that it learns of n expires one year after the date signed below, unless I inform
Signature of Client (or legal representative)	Relationship to client
Client name (printed)	