360 NEUROMUSCULAR THERAPY
CONFIDENTIAL MEDICAL HISTORY FORM

Name..... **Phone (Primary)** .....

Address..... **Email**.....

City..... **State** ..... **Zip**.....

Occupation..... **Date of Birth**..... m ☐ f ☐

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

Emergency Contact: .....**Phone:**.....

DESCRIPTION OF SYMPTOMS

Please describe the condition you are seeking treatment for and give a brief history including onset: .....

.....

.....

.....

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

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/pain do you have? .....

What activities are limited? .....

What diagnostic tests have you had (and results) for your current pain condition? .....

……

……

Any additional areas of pain other than today's main concern? .....

.....

.....

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**

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

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

Date:.....Person:.....Practice Name: .....

Date:.....Person:.....Practice Name: .....

Date:.....Person.....Practice Name: .....

Personal Physician / Case Manager:.....Practice Name: .....

CURRENT AND PAST MEDICAL PROCEDURES AND SURGERIES

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

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

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

RELEVANT TRAUMA (ACCIDENTS / FRACTURES / DENTISTRY ETC.)

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

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

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

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

CURRENT MEDICATIONS AND / OR SUPPLEMENTS

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

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

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

HABITS OF DAILY LIVING

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

Tobacco	☐ Yes	☐ No		
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	☐ Daily	☐ Now and then	☐ Binge	☐ Seldom
Fast/Processed food	☐ Daily	☐ Now and then	☐ Binge	☐ Seldom
Exercise	☐ Daily	☐ Regularly	☐ Sometimes	☐ Never
Relaxation	☐ Reading etc.	☐ Meditation	☐ Hobby	☐ None
Sleep	☐ 7 + hrs/night	☐ < 7 hrs/night	☐ Wake Rested	☐ Wake Tired
Daily activities	☐ Sitting	☐ Standing	☐ Up & down	☐ Lying down
Work activities	☐ Computing	☐ Driving	☐ Lifting, physical	☐ Repetitive
Screen Time/Day	☐ 10+ hours/day	☐ 8 hours/day	☐ < 8 hours/day	☐ Very little

CURRENT / PAST MEDICAL CONDITIONS

(please indicate **C** *for current or* **P** *for past where appropriate)*

☐ Asthma	☐ Shortness of Breath	☐ Poor Circulation	☐ Frozen Shoulder	☐ Thyroid Disorder
☐ Allergies	☐ Poor Balance	☐ Anemia	☐ Tennis/Golfer's Elbow	☐ Poor Immune System
☐ Chronic Cough	☐ Dizziness	☐ Easy Bruising	☐ Scoliosis	☐ Skin Diseases
☐ Sinusitis	☐ Deafness	☐ Chronic Diarrhea	☐ Flat Feet	☐ Skin sensitivities
☐ Headache/Migraines	☐ Hyperventilation	☐ IBS	☐ Bunions	☐ Weight loss/gain
☐ Whiplash/MVA	☐ Fainting	☐ Incontinence	☐ Sciatica	☐ Fatigue
☐ Concussion/Falls	☐ Strength Changes	☐ Crohn's Disease	☐ Osteoarthritis	☐ Excess Perspiration
☐ Torticollis/Wry Neck	☐ Recurrent Colds	☐ Celiac Disease	☐ Rheumatoid Arthritis	☐ Chronically Cold
☐ Vision Changes	☐ Heart Disease	☐ Reflux/Heartburn	☐ Osteoporosis	☐ Alcoholism
☐ Glasses/Contacts	☐ Chest Pain/tightness	☐ Stomach cramps	☐ Joint Stiffness	☐ Sleep Disorder
☐ TMJD	☐ Hypertension	☐ Bloating	☐ Hypermobility	☐ Mental Illness
☐ Clench/Grind	☐ Hypotension	☐ Constipation	☐ Diabetes	☐ Drug Abuse
☐ Dental Problems	☐ Cardiac Arrhythmia	☐ Abdominal Pain	☐ Night Cramps/RLS	☐ Depression
☐ Jaw Pain/Click	☐ Stroke/TIA/AVM	☐ Ulcers	☐ Cancer	☐ Anxiety
☐ Tinnitus/Ear Ringing	☐ Varicose Veins	☐ Hernia	☐ Polio	☐ Mental Fogginess
☐ Facial neuralgia	☐ Raynaud's	☐ Thoracic Outlet Syn.	☐ Fibromyalgia	☐ Memory Loss
☐ Facial (Bell's) Palsy	☐ Blood Clots	☐ Rotator Cuff Pain	☐ HIV/AIDS	☐ Stress at work
☐ Speech problems	☐ Phlebitis	☐ Carpal Tunnel Syn.	☐ Chronic Fatigue /ME	☐ Stress at home

Please list ALL other medical conditions that you have (even if you are not seeking treatment for them here):

_____

_____

_____

FOR WOMEN

☐ Pregnancy	☐ Menopause	☐ Stress Incontinence
☐ Menstrual Pain	☐ Pelvic Pain	☐ Hormone Replacement
☐ C-Section	☐ Urinary Urgency	☐ Diastesis Recti

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.

- ✓ 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.
- ✓ I understand that 360 NeuroMuscular Therapy often participates as a teaching clinic, and that resident clinicians may observe or participate in the care provided, and that my case may be discussed (without identifying information) for educational purposes.

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:

_____

_____

_____

_____

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**