Neuromuscular Therapy ● Confidential Client Information

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Name_____**Home #**_____

Address_____**Cell #**_____

City _____**State**_____**Zip**_____**Date of Birth (month/day)**_____

Email_____**Sex**_____**Occupation**_____**Referred by**_____

Primary reason for visit_____

Specific goals you hope to achieve coming here _____

How long have you had this problem_____

How did the pain arise_____

Are there any specific activities which aggravate your pain or discomfort_____

Does your condition keep you awake at night_____

Describe the nature of pain. Sharp, dull, burning, aching, diffuse, electrical, etc._____

What have you tried, present and past, for your condition_____

Any MRI's/X-Rays/Bones Scans, etc...Describe results_____

Was it successful and did it help at all...Describe_____

Are you taking medications_____**Describe**_____

Are there any side-effects to your medication you're aware of_____**Describe**_____

Do you have any shooting pain, numbness, or tingling down your arms, hands, hips or legs_____**Describe**_____

Is your condition affecting/limiting ANY activities or exercise/sports _____

Have you ever had this or a similar condition before. If so, how was it resolved_____

Have you noticed your posture affected by your condition_____

How many hours do you sit each day?_____

What concerns you the most about your condition (your biggest fear)_____

What aspect of your life are you missing most and is most affected by your condition...i.e. sports, work, sex, daily activities, family, picking up your kids, etc._____

What do you hope will happen once you successfully complete treatment_____

What will happen to you if I can't help, your problem isn't solved, or I don't accept you for treatment_____
_____

Please check any of the following which apply to you, past or present:

__accident	__blood disorder	__cancer	__breast augmentation
__whiplash	__disc disorder	__heart attack	__broken bones
__neck pain	__low back pain	__seizures	__high blood pressure/cholesterol
__surgery	__abdominal pain	__headaches	__varicose veins
__bursitis	__carpal tunnel syndrome	__diabetes	__joint aches/arthritis
__HIV/Aids	__strains/sprain	__hepatitis	__decreased range of motion
__dizziness	__decreased strength	__pregnant	__other

Please explain any checks in the space below with approximate date of each occurrence:

_____
_____

Please read the following and sign below:

I, _____understand that Neuromuscular Massage Therapy (NMT) given here is for the purpose of muscular spasm/tension relief related to soft-tissue dysfunction. I _____understand the treating therapist does not prescribe medical treatment, diagnose illness, disease or any other physical or mental disorder. I have been made aware that NMT is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have. Because the treating therapist must be aware of existing condition, I have stated all my known medical conditions and take it upon myself to keep the treating therapist updated on my physical health. I understand that regardless of insurance reimbursements I am ultimately responsible for full payment of my account and payment is due at the time services are rendered. I understand that there is a 24 hour cancellation policy, and there will be a charge for late cancellation.

Signature _____ Date _____