Neuromuscular Therapy ● Confidential Client Information

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Neck/Headache Pain Intake Form

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 your neck/headache pain_____

How did your neck pain arise_____

Are there any specific activities which aggravate your neck pain or discomfort_____

Does your neck pain keep you awake at night_____

What is the nature of pain? How would you describe it? Is it sharp, dull, burning, aching, diffuse, electrical, etc._____

Do you get headaches? Y__N___Where? Behind eyes, Temples, Eyes, Top of head, Base of Skull, Sinuses, Other_____

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

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_____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_____

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**
__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**	**__hypoglycemia**	**__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 _____