360 NeuroMuscular Therapy

CONFIDENTIAL MEDICAL HISTORY FORM

Legal Name..... **Preferred Name**.....

Primary Phone..... **Email**.....

Address.....

Occupation..... **Date of Birth**.....

Gender Identity: **male** ☐ **female** ☐ **other** ☐ **Pronouns**.....

How did you hear about 360 NMT®?.....

Emergency Contact..... **Relation to Patient**.....

Emergency Contact Primary 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 this main concern *(please circle one)*: getting worse? getting better? staying the same?

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, including results, for your current main concern?.....

.....

.....

Any additional areas of concern/symptoms/pain?.....

.....

.....

TODAY'S SYMPTOM INTENSITY RATING *(mark with an 'X' on the line)*

Use the Defense and Veterans' Pain Rating Scale chart for reference.

0 ____ 1_____2 ____ 3_____4 ____ 5_____6 ____ 7_____8 ____ 9_____ 10

HEALTH PROFESSIONALS ALREADY CONSULTED (list the most recent first)

Name:..... Profession:..... Date Seen: .....

Name:..... Profession:..... Date Seen: .....

PCP / Case Manager: .....At: .....

CURRENT AND PAST MEDICAL PROCEDURES AND SURGERIES

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

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

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

CURRENT AND PAST TRAUMA / ACCIDENTS / FALLS / FRACTURES / DENTISTRY

(*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

Approximately how many hours of sleep do you get regularly? _____ **Do you wake rested or tired?** _____

How often do you exercise? ☐ Never ☐ Daily ☐ Regularly ☐ Sometimes ☐ On the weekends

What is your typical alcohol consumption? ☐ Daily ☐ Social ☐ Weekend ☐ None

What do you do for relaxation? _____

Do you use a tobacco product on a regular basis? ☐ Yes ☐ No

What is your typical daily caffeine consumption in 8oz cups? ☐ >5 cups/day ☐ 2-5 cups/day ☐ 1-2 cups/day ☐ None

What is your typical daily consumption (in 8oz cups) of fluids that do not contain caffeine or sugar? ☐ 8+ glasses/day ☐ 4 glasses/day ☐ 2 glasses/day ☐ None

CURRENT AND PAST MEDICAL CONDITIONS

Please place a 'C' for current and 'P' for past medical conditions in the boxes below.

☐ Asthma	☐ Shortness of Breath	☐ Poor Circulation	☐ Frozen Shoulder	☐ Thyroid Disorder
☐ Allergies	☐ Poor Balance	☐ Anemia	☐ Clotting Factors	☐ Urinary Urgency
☐ Chronic Cough	☐ Dizziness	☐ Easy Bruising	☐ Scoliosis	☐ Skin Diseases
☐ Sinusitis	☐ Deafness	☐ Chronic Diarrhea	☐ Flat Feet	☐ Skin sensitivities
☐ Headaches	☐ Hyperventilation	☐ Pelvic Pain	☐ Bunions	☐ Weight loss/gain
☐ Whiplash/MVA	☐ Fainting	☐ Incontinence	☐ Sciatica	☐ Fatigue
☐ Concussion	☐ 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/Alcohol Abuse
☐ Dental Problems	☐ Cardiac Arrhythmia	☐ Abdominal Pain	☐ Night Cramps	☐ 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
☐ Pregnancy	☐ Menopause	☐ Stress Incontinence	☐ C-Section	☐ Diastasis Recti
☐ Menstrual Pain	☐ COVID-19	☐ Leg Cramps	☐ Migraines	☐ Falls
☐ Irritable Bowel Syndrome	☐ Restless Leg Syndrome	☐ Poor Immune System	☐ Hormone Replacement	☐ Tennis/Golfer's Elbow

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

_____

_____

_____

_____

_____

_____

INFORMED CONSENT, LIABILITIES, AND CANCELATION POLICY

I recognize that neuromuscular and therapeutic massage 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 (360 NMT®) 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 will discuss my own physical limitations and/or suspected health concerns with 360 NeuroMuscular Therapy, LLC.

The confidential information contained on my Medical Health History form and Daily Intake forms belongs to me and are securely stored by 360 NMT®. 360 NeuroMuscular Therapy LLC is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand it is my responsibility to update 360 NMT® with any changes to my medication or medical history and may be required to complete this form again to update medical information.

I agree to contact 360 NMT® if I test positive for any communicable disease (this includes COVID-19) and there is a possibility that I was contagious at the time of my appointment.

I also agree to report to 360 NMT® if I traveled anywhere communicable diseases (this includes COVID-19) may be present prior to my appointment.

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.

I agree to give at least 24 hours' notification. If I cancel with less than 24 hours' notice, or completely miss an appointment without prior notice, I am responsible for paying the full price of the appointment. Late cancelations due to emergencies or sudden illness may not be changed.

I understand if I arrive for my appointment and am ill, or cause concern that I might be ill, 360 NMT® has the right to refuse me treatment and charge me the full price of the appointment.

I understand that 360 NMT® often participates as a teaching clinic, and that other clinicians or students may observe or participate in the care provided, and that my case may be discussed (without identifying information) for educational purposes.

Signature (or legal representative)	Relationship to patient (if legal representative)
Printed Name	Date