NEUROMUSCULAR THERAPY

CONFIDENTIAL MEDICAL HISTORY FORM

Today's Date: ……….………….

Name……….……….……….………… Phone (Primary) …….……….…………..………………………….…

Address ………………………………………………………………………………………….………………….

City ……….……….……….……….. State ……….. Zip ……….……….…………..………………….…

Email ……….……….……….……….……….………..……….……….…………………………….

Occupation ……….…………………………. Date of Birth ……….……….……………………………….

Gender Identity: male ▢ female ▢ other ▢

How did you hear about my practice? ……….……….……….……….……………………………….

……….……….……….……….……….……….……….……….……….……….…………………….

Emergency Contact ……….……….……….……….……….……….……….…………………….

Relationship to Patient ……….……….……….……….……….……….……….…………………….

Emergency Contact Phone ……….……….……….……….……….………………………………….

DESCRIPTION OF SYMPTOMS

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

……….……….……….……….……….……….……….……….……….……….…………………….…

……….……….……….……….……….……….……….……….……….……….…………………….…

……….……….……….……….……….……….……….……….……….…………………….

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What are your goals for treatment?..……….……….……….……….……….…………………….

……….……….……….……….……….……….……….……….……….…………………………..

Is the main problem: ▢ getting worse ▢ getting better ▢ staying the same

What makes your pain/discomfort worse?

………

What makes your pain/discomfort better?

………

………

What other symptoms do you have (ie. numbness, tingling, tight, etc.)?

………

………

What activities (if any) are limited due to your condition?

………

………

What diagnostic tests have you had for your current pain condition and what are the results? (MRI, xrays, etc.?). Please provide a copy of the <u>findings</u> from the report.

………

………

………

In addition to today's main concern, do you have other areas of concern?

………

………

………

TODAY'S SYMPTOM INTENSITY RATING: 0 is no pain, 10 is extreme debilitating pain.
Circle one below.

0 1 2 3 4 5 6 7 8 9 10

HEALTH PROFESSIONALS YOU HAVE CONSULTED for this condition (most recent first)

Name/Title: ………………… Profession ………………… Date Seen: ………………………………

Name/Title: ………………… Profession ………………… Date Seen: ………………………………

Name/Title: ………………… Profession ………………… Date Seen: ………………………………

Primary Care Physician's Name:

……………………..……...…………..……...……...…………..…………………..

Practice Name: ……………………………………………..……...……....…………..………...………..

HISTORY OF MEDICAL PROCEDURES AND SURGERIES

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

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

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

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

Additional notes here: ………………………………………..……..……....………………..………..…...

HISTORY OF INJURIES: (falls, fractures, MVA's, etc.)

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

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

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

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

CURRENT MEDICATIONS AND SUPPLEMENTS, including dose.

Taking: ………….……… for ……………………………….……… dose: ………………………………

Taking: ………….……… for ……………………………….……… dose: ………………………………

Taking: ………….……… for ……………………………….……… dose: ………………………………

Taking: ………….……… for ……………………………….……… dose: ………………………………

HABITS OF DAILY LIVING:

Approximately how many hours of sleep do you get regularly?...

Do you wake up feeling rested or tired?…………………………………………………………………..

How often do you exercise and what do you do for exercise? ……………………………………….....

……………………………………………………………..……………………………………..

What is your typical alcohol consumption?

▢ Daily ▢ Social ▢ Weekend ▢ None ▢ No. of drinks per week

What do you do for relaxation? ………………………………………………………………..

Do you use tobacco products? ▢ Yes ▢ No How often? ………………………

What is your typical daily caffeine consumption (per 8oz cups)?

▢ >5 cups/day ▢ 2-5 cups/day ▢ 1-2 cups/day ▢ None

What is your typical daily consumption 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.

▢ Covid-19 ▢ Shortness of Breath ▢ Poor Circulation
▢ Frozen Shoulder ▢ Thyroid Disorder ▢ Allergies
▢ Poor Balance ▢ Anemia ▢ Clotting Factors
▢ Urinary Urgency ▢ Chronic Cough ▢ Dizziness
▢ Bruise Easily ▢ Scoliosis ▢ Skin Diseases
▢ Sinusitis ▢ Hard of Hearing ▢ Chronic Diarrhea
▢ Flat Feet ▢ Skin sensitivities ▢ Headaches
▢ Hyperventilation ▢ Pelvic Pain ▢ Whiplash/MVA
▢ Bunions ▢ Sudden Weight loss/gain ▢ Sciatica
▢ Fainting ▢ Incontinence ▢ Fatigue
▢ Concussion ▢ Changes in strength ▢ Crohn's Disease
▢ Osteoarthritis ▢ Asthma ▢ Cancer
▢ Excess Perspiration ▢ Torticollis/Wry Neck ▢ Frequent Colds

▢ Celiac Disease ▢ Rheumatoid Arthritis ▢ Chronically Cold

▢ Vision Changes ▢ Heart Disease ▢ Reflux/Heartburn

▢ Osteoporosis ▢ Alcoholism ▢ Glasses/Contacts

▢ Chest Pain ▢ Autoimmune disorder ▢ Stomach cramps

▢ Joint Stiffness ▢ Sleep Disorder ▢ TMJD

▢ Hypertension ▢ Bloating ▢ Hypermobility

▢ Mental Illness ▢ Clench/Grind ▢ Hypotension

▢ Constipation ▢ Diabetes ▢ Tennis/Golfer's Elbow

▢ Drug/Alcohol Abuse ▢ Dental Problems ▢ Cardiac Arrhythmia

▢ Abdominal Pain ▢ Night Cramps ▢ Depression

▢ Jaw Pain/Click ▢ Stroke/TIA/AVM ▢ Ulcers

▢ Anxiety ▢ Tinnitus/Ear Ringing ▢ Varicose Veins

▢ Hernia ▢Polio ▢ Mental Fogginess

▢Facial neuralgia ▢ Raynaud's ▢ Thoracic Outlet Syn.

▢ Fibromyalgia ▢ Memory Loss ▢ Facial (Bell's) Pals

▢ Blood Clots ▢ Rotator Cuff Pain ▢ HIV/AIDS

▢ Stress at work ▢ Speech problems ▢ Phlebitis

▢ Carpal Tunnel Syn. ▢ Chronic Fatigue ` ▢ Stress at home

▢ Pregnancy ▢ Menopause ▢ Stress Incontinence

▢ C-Section ▢ Diastasis Recti ▢ Menstrual Pain

▢ Leg Cramps ▢ Migraines ▢ Irritable Bowel

▢ Restless Leg Syndrome

Please add details here to any boxes checked above:

………………………………………………………………..………………………………………………..

………………………………………………………………..………………………………………………..

Please list any other medical conditions you have that are not listed above (even if you are not seeking treatment for them):

………………………………………………………………..…………………………………………………...

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INFORMED CONSENT, LIABILITIES, AND CANCELLATION 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 Jennifer Parmenter harmless for any responsibility.

I hold harmless and agree to indemnify Jennifer Parmenter from any claims, damages, losses, expenses, costs and liabilities arising from the delivery and receipt of services. I will fully disclose my own physical limitations and/or suspected health concerns with Jennifer Parmenter.

I understand it is my responsibility to update Jennifer Parmenter 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 Jennifer Parmenter if I test positive for any communicable disease, including COVID-19, and let her know if there is a possibility that I was contagious at the time of my appointment.

I am aware of fees for treatment and accept responsibility for payment in full.

I agree to give at least 24 hours'notification for cancellation of an appointment. 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 cancellations due to emergencies or sudden illness will not be charged.

I understand if I arrive for my appointment and am ill, Jennifer Parmenter has the right to refuse treatment and charge the full price of the appointment.

Printed Name : ……..……..………………………...   Date: ……………………………………...

Signature: ………………………………………….