

Windham Health Center

NeuroMuscular Therapy LLC

87 Indian Rock Road, Windham, New Hampshire 03087-1656

(603) 894-6402

Client Information

(Please answer all areas; filling out this form completely will help ensure the best possible care.)

Name: _____ Date: _____

Date of Birth: _____ Home Phone # _____

Do you have any of the following today:

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> Cold or Flu | <input type="checkbox"/> Open cuts | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Bruises | <input type="checkbox"/> Skin rash-where: | |
| <input type="checkbox"/> Contact lenses | <input type="checkbox"/> Are you pregnant? Due: | |

Have you ever had the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Clot/DVT | <input type="checkbox"/> Dislocated Joint |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Lupus | <input type="checkbox"/> Stroke/CVA |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Neuropathy/Numbness |
| <input type="checkbox"/> Fibromyalgia Syndrome | <input type="checkbox"/> Heart Attack/MI | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Cortisone Injection: | |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Chemo/Radiation Therapy: | |

What is the major complaint or condition you are seeking help for?

When did this begin? _____

What brought it on? _____

What have you done to get relief? _____

What positions/activities aggravate the condition? _____

What does this condition prevent you from doing? _____

Is this condition: worsening improving unchanged.

Have you seen a physician for this? Yes / No

May we contact your physician? Yes / No Initial here:

Physician Name / Number: _____

Are you now under medical/therapeutic treatment? Yes / No

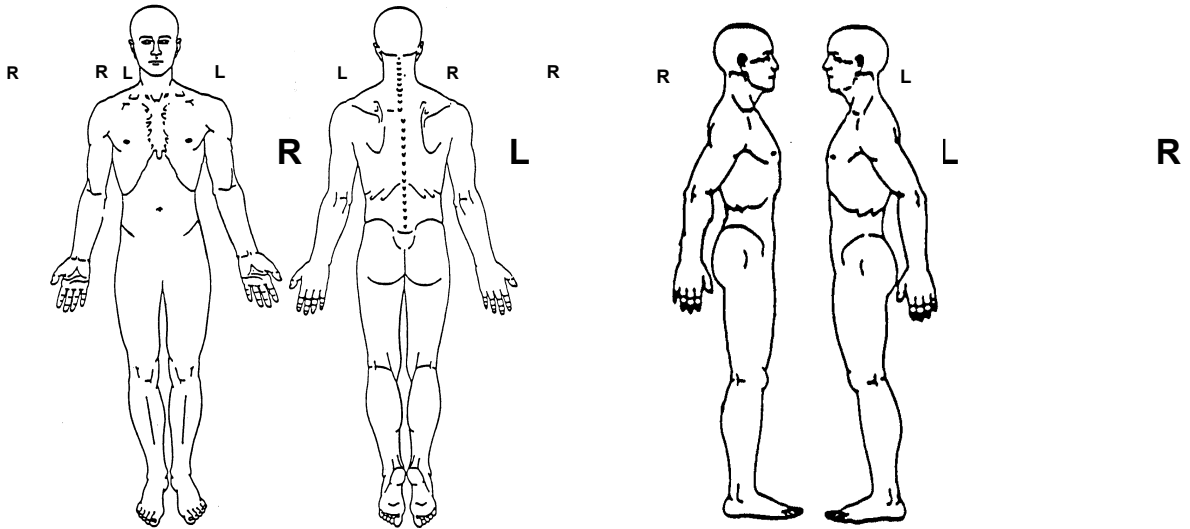
Please list all medications and nutritional supplements you are taking: _____

Women

- Yes No Are you pregnant?
 Yes No Do you have PMS or menstruation problems?
 Yes No Breast pain?
 Yes No Diagnosed breast condition?
Please specify: _____
 Yes No Breast Implants?
Type: _____
How long ago?: _____
Any Problems?: _____
Please specify: _____
 Yes No Breast Surgery?
Type: _____
How long ago?: _____
Any Problems?: _____
Please specify: _____
 Yes No Interested in discussing
massage for breast health?

Please list all surgeries in your lifetime: _____

Please color in your conditions, scars and injuries:



List other therapies you currently receive: _____

Please list any additional comments regarding your health and well-being: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone Number: _____

Email Address: _____

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

The information I have provided is accurate and complete to the best of my knowledge. I understand that massage therapists do not diagnose or treat disease, and that any care or recommendation I receive in this clinic or from my therapist is not a substitute for a physician's care. I take responsibility for alerting my therapist of any changes to my health status, medications and therapies before the session, as well as any and all responses perceived to be a result of massage therapy as soon as I become aware of them. I understand that no sexual activity, comment or innuendo will be tolerated. This facility reserves the right to refuse services at their discretion based upon the client's conditions, therapist's skill set, client attitude or action, etc, without explanation or prior notice, and I agree to this policy. I give consent to this clinic for the use and disclosure of my Protected Health Information (PHI) for the specific purposes of providing treatment to me, receiving payment for services rendered to me, and for general administrative operations. I understand that I have the right to request restrictions on the use and disclosure of my PHI, but this clinic is not required to agree to these restrictions and may refuse care. If the facility agrees with my restrictions, the restriction is considered binding. You may contact me for appointment reminders, schedule changes, or other needs.

Signature: _____

Date: _____