



Therapy

Designed for You

CLIENT HEALTH & MEDICAL HISTORY

82 Palomino Lane, Suite 501, Bedford, NH 03110
603-627-6381

A health and medical history aids us in providing treatment as muscular therapy may impact medication effectiveness or worsen existing health conditions. This Information will be used to structure safe therapy sessions for you.

Name: _____ Date: _____

Home Phone: (____) _____ Work Phone: (____) _____

Address _____ Street _____ City _____ State _____ Zip Code _____

Email: _____ Join our Email Newsletter? Yes No

Occupation: _____ Sex: M/F Date of Birth: _____

How did you hear about us _____

Reason for visit: (circle all that apply) shoulders low back neck legs upper back
feet arms jaw chest stress headaches just stressed out!

Exercise	Work/Home Activity	Habits
<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Daily <input type="checkbox"/> Occasional	<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor <input type="checkbox"/> Substantial Computer Work <input type="checkbox"/> Carrying Children	<input type="checkbox"/> Smoking Packs/Day ____ <input type="checkbox"/> Alcohol Drinks/Week ____ <input type="checkbox"/> High Stress Level Reason _____
Injuries/Surgeries	Description	Approximate Date
<input type="checkbox"/> Fall <input type="checkbox"/> Broken Bones <input type="checkbox"/> Dislocations <input type="checkbox"/> Surgery(ies)	_____ _____ _____ _____	_____ _____ _____ _____
Medications	Allergies	Vitamins/Herbs/Minerals
_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____

Daily Water Intake: 0-19 oz. 20-36 oz 37-48 oz 49-64 oz over 64 oz.
 Daily Caffeine/Soda: 0-19 oz 20-36 oz 37-48 oz 49-64 oz over 64 oz.

How many fresh fruits do you eat daily: 0-2 3-5 more than 5
 How many fresh vegetables to you eat daily: 0-2 3-5 more than 5
 How much protein: Don't know 5 grams+ 10 grams+ 15 grams+ over 20 grams
 Approximate Body Weight: 100-130 131-160 161-190 191-225 Over 225

Do you think you would benefit from nutritional counseling to meet your wellness goals? Yes No

Current Medical Signs & Symptoms			
Symptom	Yes	No	Location: (describe)
1. Any active infections?			
2. Any swelling, edema or tendency to swell?			
3. Any numbness or abnormal sensation?			
4. Any pain or tenderness?			

Accident Information

Is your current complaint related to an accident:

- Yes
- No

If so, what type of accident:

- Auto Accident
- Work Site Accident
- Attorney Engaged
- Name, Address & Phone: _____

Insurance Coverage Available

- Policy Number _____
- Insurance Company _____
- Contact Information (Phone) _____

Please read and sign below:

Note: We accept insurance assignment during treatment for approved cases. You are responsible for all unpaid fees and must advise us immediately if you engage an attorney. If your attorney requires insurance assignment to their office, you will be asked to pay for your treatment as it occurs & your attorney will obtain reimbursement for you.

I verify that all information provided is correct and current to the best of my knowledge. I understand that any information provided to my therapist is for exclusive use in providing muscular therapy and will not be discussed with any other persons without my express written permission. I understand that I am responsible for reporting changes in my general health and medications prior to future treatments.

Signature

Date