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. *Clients with active cancer or a cancer history should request the Cancer History form.*

Name: _____ Date: _____

Best Phone: (____)_____ Alt. 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 so we can send a "thank you" _____

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
☐ None ☐ Moderate ☐ Heavy ☐ Daily ☐ Occasional	☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Substantial Computer Work ☐ Carrying Children	☐ Smoking Packs/Day ___ ☐ Alcohol Drinks/Week ___ ☐ High Stress Level Reason _____

Injuries/Surgeries	Description	Approximate Date
☐ Fall ☐ Broken Bones ☐ Dislocations ☐ 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
Do you eat protein at every meal? Y __ N __ Do you understand how protein & water affect muscles? Y __ N __

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

Only complete this section if your treatment is related to a Workers' Compensation Case or Automobile Accident which has approved therapeutic massage.

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

  _____

- ☐ Insurance Policy/Case Information
  - ☐ Policy/Case Number _____
  - ☐ Insurance Company_____
  - ☐ Contact Person _____
    - Phone_____
    - Fax _____
    - Address _____
    - _____

For Insurance Cases your signature below also indicates your agreement with and to the following statement.

> TDFY accepts 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*