

client signature _____

Personal Information

name _____

address _____

city _____ state _____ zip _____

How would you like to be contacted to confirm appointments?

home phone _____ cell phone _____

work phone _____

email _____

occupation _____

referred by _____

emergency contact name _____ emergency contact phone _____

physician's name _____ physician's phone _____

Laser and Neuro Muscular Therapy Experience

Have you had Laser Therapy? Yes No

Have you had Neuromuscular Therapy? Yes No

What are your goals for treatment? _____

Health History (Please Check)

Musculoskeletal

Bone or joint disease
Tendonitis/Bursitis
Arthritis/Gout
Jaw Pain (TMJ)
Lupus
Spinal Problems
Migraines/Headaches
Osteoporosis

Circulatory

Heart Condition
Phlebitis/Varicose Veins
Blood Clots
High/Low Blood Pressure
Lymphedema
Thrombosis/Embolism

Respiratory

Breathing Difficulty/Asthma
Emphysema
Allergies, specify: _____
Sinus Problems

Nervous System

Shingles
Numbness/Tingling
Pinched Nerve
Chronic Pain
Paralysis
Multiple Sclerosis
Parkinson's Disease

Reproductive

Pregnant, stage _____
Ovarian/Menstrual Problems
Prostate

date of initial visit _____

Current Health

Do you exercise regularly and/or participate in any sports? Y N
If yes, what kind of exercise/sports? _____

Do you perform any repetitive movement in your work, sports or hobby? Y N
If yes, describe _____

Do you sit for long hours at a workstation, computer or driving? Y N
If yes, describe _____

Do you experience stress in your work, family, or other aspect of your life? Y N
If yes, describe _____

Are you experiencing tension, stiffness, discomfort or pain? Y N
If yes, describe _____

Have you recently had an injury, surgery, or areas of inflammation? Y N
If yes, describe _____

Any medical diagnosis? Y N
If yes, describe _____

Do you have sensitive skin? Y N

Do you have any allergies to oils, lotions or ointments? Y N
If yes, please explain _____

List any medications you are currently taking _____

Had any cortizone shots within 1 week? Y N

List any known allergies _____

Skin

Allergies, specify: _____
Rashes
Cosmetic Surgery
Athlete's Foot
Herpes/Cold Sores

Digestive

Irritable Bowel Syndrome
Bladder/Kidney Ailment
Colitis
Crohn's Disease
Ulcers

Psychological

Anxiety/Stress Syndrome
Depression

Other

Cancer/Tumors
Diabetes
Drug/Alcohol/Tobacco Use
Contact Lenses
Dentures
Hearing Aids

Any other medical condition(s) not listed: _____

Please explain any of the conditions that you have marked above : _____

It is my choice to receive Laser and Neuromuscular Therapy (NMT). I am aware of the benefits and risks of Laser and NMT as explained to me by my therapist. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques deployed during sessions.

I acknowledge that Laser and NMT is not a substitute for medical care, medical examinations, or diagnosis.

I have stated all medical conditions that I am aware of and HAVE informed my therapist of any changes in my health status. I agree to communicate any new changes that may occur to my health and I expect my therapist to provide a safe treatment to the best of her skills and knowledge.

X _____
Client Signature Date