NMTP
NEUROMUSCULAR THERAPY
OF PEPPERELL

Client Intake Form

Name____Best phone______________________

Date of initial visit____________ How did you hear about NMTP? _________________________

Mailing address____

Email______________________DOB____________Age_____Occuption_____________________

Emergency contact______________________________Relationship____________Phone________

The following information will be used to help plan safe and effective sessions. Please answer the questions to the best of your knowledge.

Have you had professional massage therapy before? Y N

If yes, how often and for what conditions? ____

Do you have difficulty lying on your front, back or side? Y N

Do you have sensitive skin or allergies to oils, lotions or ointments? Y N

If yes, please explain. ____

Are you wearing contact lenses? ___ hearing aids? ___ Other external articles? ________________

Do you sit for long hours without getting up? Y N

Do you perform any repetitive movement in your work, sports or hobbies? Y N

If yes, please explain. ____

Do you experience: Muscle tension__ anxiety__ insomnia__ irritability__ pain__ other____________

Do you have a change in range of motion? Y N

If so, where? ____

Do you have an unexplained loss of strength? Y N

If so, where? ____

Do you have particular goals in mind for this session? Y N

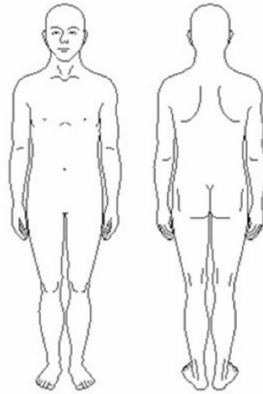
If yes, please explain. ____

Do you exercise regularly? Y N

If yes, please explain. ____

What is your current discomfort range? 1 being least and 10 most. (circle) 1 2 3 4 5 6 7 8 9 10
When did you first notice your discomfort? ____
Have you been treated for this condition? Y N
If yes, please explain. ____

Please mark and label the diagram with aches, pains, numbness, or other problems.



X – Stabbing Pain
O – Numbness
//// - Aches
+++ - Pins and Needles
----Burning

Treatment (past and current): Are you currently seeing a specialist for this condition?
MD? __ PT? __ Functional Medicine Doctor? __ Acupuncturist? __ Chiropractor? __
Other? ____
Please list your current medications on the back of this sheet or attach list, if applicable.

Conditions: Please check any condition(s) listed below that apply to you:

__ Contagious skin condition
__ open sores or wounds
__ easy bruising
__ recent accident or injury
__ recent surgery
__ artificial joints
__ sprains / strains
__ current fever
__ swollen glands
__ allergies / sensitivities
__ heart condition
__ blood pressure __ high __ low
__ circulatory disorder
__ pregnancy ____ months

__ phlebitis (inflammation of a vein)
__ varicose veins or blood clots
__ rheumatoid arthritis __ osteoarthritis __ tendonitis
__ epilepsy
__ headaches __ migraines
__ cancer
__ diabetes
__ decreased sensation
__ back disorders __ neck disorders
__ fibromyalgia
__ TMJD (jaw disorders)
__ carpal tunnel disorder
__ high cholesterol
__ other _________________________________

Please explain any condition that you have marked above (use back if necessary) ____________________

____

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Is there any other information that would be useful in planning a safe and effective treatment session for you?

____

Client / Therapist (NMTP) agreement

Please read and complete the following:

I, ________________________________ (print name) understand the treatment I receive is provided for the basic purpose of relief of muscular pain and tension and/or relaxation. If I experience discomfort during this session, I will immediately inform the therapist so that treatment may be adjusted as needed. I further understand that this treatment should not be construed as a substitute for medical examination, diagnosis and that I should see a physician, chiropractor or other qualified medical specialist for any spinal or skeletal adjustments, diagnosis, prescription or to treat any physical or mental illness, and that nothing said in the course of the session given, should be construed as such. Because neuromuscular therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent of legal guardian for any client under the age of 17.

Signature of client or legal guardian ____________________________________Date _______________

Cancellation Policy:

It is understood that unexpected and emergency situations arise from time to time, however, the below policy will apply otherwise. Thank you for your understanding.

30-minute session - 24 hours notice requested – 12 hours notice required or full amount of session will be charged **

60-minute session - 48 hours notice requested – 24 hours notice required or full amount of session will be charged **

90-minute session - 72 hours notice requested – 48 hours notice required or full amount of session will be charged**

** If your appointment is filled, there will be NO charge for the cancelled appointment.

Missed appointments:

Every effort will be made to contact you via phone, email and text, if applicable. If there is no response, all future appointments will be cancelled after 1 week.