

MYOPAIN SOLUTIONS

CONFIDENTIAL MEDICAL HISTORY FORM

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Name Phone (Home)
 Address Phone (Work)
 City State Zip Phone (Cell) M / F
 Occupation Date of Birth Email
 How did you hear about Myopain Solutions?

SECTION 1 **CURRENT / PAST MEDICAL CONDITIONS** *(place an X in the box to the right)*

Head / neck	X	Shoulder / arm	X	Back / pelvis / legs	X	General	X
Headache/ migraine		Rotator cuff syndrome		Spinal deformity		Epilepsy / seizures	
Sinus pain		Pain between scapulae		Back pain / surgery		Anemia	
Facial (Bell's) palsy		Shoulder injury (surgery)		Sacroiliac dysfunction		Atherosclerosis	
Facial neuralgia		Frozen shoulder		Sciatic pain		Easy bruising	
Whiplash / MVA		Carpal tunnel syndrome		Groin pain		Blood clots	
Concussion, falls		Tennis elbow		Hernia (repair)		Skin sensitivities	
Broken neck		Golfer's elbow		Hip pain, bursitis, labrum		Skin diseases	
Torticollis		Fractures: arm, wrist		Knee trauma		Malignancy/cancer	
Shooting pain in neck		Ligament sprains		Ankle trauma		Low blood pressure	
Hypothyroidism		Dupuytren's contracture		Foot pain / surgery		High blood pressure	
Other endocrine		Pins and needles		Varicose veins, phlebitis		Osteoarthritis	
Jaw pain or click		Cold hands (Raynaud's)		Night cramps, RLS		Rheumatoid arthritis	
Bruxism, grinding		Arthritis		Poor circulation		Joint stiffness	
Teeth, gum disease		Chest and abdomen		Clumsiness, trips or falls		Hypermobility	
Glasses/contact lens		Chest tightness		Flat feet		Diabetes	
Eye strain		Chest pain		Mostly Female		Abscesses / sores	
Light sensitivities		Heart disease		Pregnant		Weight loss / gain	
Loss of taste / smell		Rheumatic fever		Recently post-partum		Mental illness	
Recurrent colds / flu		Arteriosclerosis		IUD		Stress at work	
Hay fever / allergies		Indigestion		Osteopenia -porosis		Stress at home	
Stroke / TIA / AVM		Stomach cramps		Painful breasts		Anxiety / nervousness	
Poor balance		GERD/reflux/heartburn		Lymph node biopsy		Anger / fear / grief	
Dizziness / vertigo		Crohn's disease		Mastectomy/lumpectomy		Depression	
Fainting		Cœeliac's disease		PID, IC, other pelvic floor		Fibromyalgia	
Deafness		Ulcers, diverticulitis		Dys / amenorrhea		Mental fogginess	
Ringing in the ear		Irritable bowel synd.		Uterine abnormalities		Myofascial pain	
Thoracic inlet syndrome		Constipation		Urinary incontinence		Chronic Fatigue Synd	
Cervical rib		Loose bowel		Painful intercourse		Fatigue in general	
Recurrent sore throat		Breathing		Mostly Male		Malaise	
Tight throat		Shortness of breath		Testicular / groin pain		HIV / AIDS / TB	
Difficulty swallowing		Hyperventilation		Painful / frequent urination		Poor immune system	
Speech impediment		Asthma		Bladder disease (I.C.)		Excess perspiration	
Neck / cranial surgery		Sighing, yawning, holding		Prostate problems		Sports injuries	

Other not listed:.....
 Family history of:
 Current medical diagnoses:.....
 Emergency contact: Phone

Please continue to the next page

SECTION 7 **INFORMED CONSENT AND CANCELATION POLICY**

I recognize that neuromuscular and therapeutic massage services can be legally provided in Massachusetts without referral from a physician. By signing this document, I assume all risk for my health and wellbeing, and hold harmless any responsibility Myopain Solutions or any persons involved in this company.

I hold harmless and agree to indemnify Myopain Solutions its agents, servants, employees from any claims, damages, losses, expenses, costs and liabilities arising from the delivery and receipt of services from the company other than that which is due to the gross negligence or willful misconduct of its agents, servants and/or employees.

I have discussed my own physical limitations and/or suspected health concerns with Myopain Solutions staff.

- ✓ The confidential information contained on these pages and the daily intake forms belongs to me and is securely stored at Myopain Solutions.
- ✓ Treatment will follow my informed consent and I can refuse aspects of the treatment at any time.
- ✓ I am aware of all prices per treatment and accept responsibility for payment in full at the conclusion of each session.
- ✓ I agree to give a 24-hour cancellation notification (emergencies excepted). I may be charged a \$50 cancellation fee if Myopain Solutions are unable to fill the appointment within that 24-hours.
- ✓ A completely missed appointment (no-show), without prior notice, will incur the full treatment fee.

Signature _____ **Printed name** _____

Parent / Guardian’s signature if under the age of 18 _____

Signees relationship _____ **Date** /...../

SECTION 8 **AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION** (If needed)

I, _____, hereby authorize Myopain Solutions to discuss my treatment and disclose my massage therapy records to the following health providers:

I understand that I may revoke this authorization at any time, but that I may not hold Myopain Solutions responsible for acting in a reasonable reliance on this statement prior to the time that it learns of my revocation. I understand that this authorization expires one year after the date signed below, unless I inform Myopain Solutions otherwise.

Signature of Client (or legal representative)

Relationship to client

Client name (printed)

Date