Sum of all Points Neuromuscular Therapy/Trigger Point Methodology

CONFIDENTIAL MEDICAL HISTORY FORM

Name _____**Phone** _____ _

Address _____

City_____**State**_____**Zip Code**_____

Email: _____**Date of Birth:** _____

Emergency Contact: _____**Phone:** _____

Occupation_____**Allergies**:_____

Medications /Supplements (*list all***):**
_____

_____

_____

DESCRIPTION OF SYMPTOMS /DIAGNOSIS

Please describe the condition you are seeking treatment for and give a brief history including onset and medical diagnosis (if you have one).

_____

_____

List all areas of discomfort, sensory symptoms or pain *(seemingly related or unrelated)***:**
_____

_____

Pain Frequency: (*Please Circle***): Constant, off/on, at rest or with activity, other**_____

At what time of day is your pain the worse? _____

Have you ever injured this area before? _____

Have you ever been in an accident (automobile, work, falls, etc.)?_____

_____

List any related treatments received for this injury including diagnostic tests:

_____

_____

What activities or modalities (ice, heat) relieve the pain? _____

_____

Is there anything that you do that creates or increases the pain? _____

_____

What are the physical duties required of your occupation? _____

_____

What activities/hobbies do you enjoy? Are you able to do them currently?

_____

_____

Are there any activities of daily living you find difficult *(ie: brushing your hair, reaching a cabinet):*

_____

_____

Please list exercise and stress reduction activities (including frequency):

_____

_____

In what position do you sleep? _____How many hours/night? ____

Are you currently seeing any other healthcare professionals? _____

What are your goals for therapy? _____

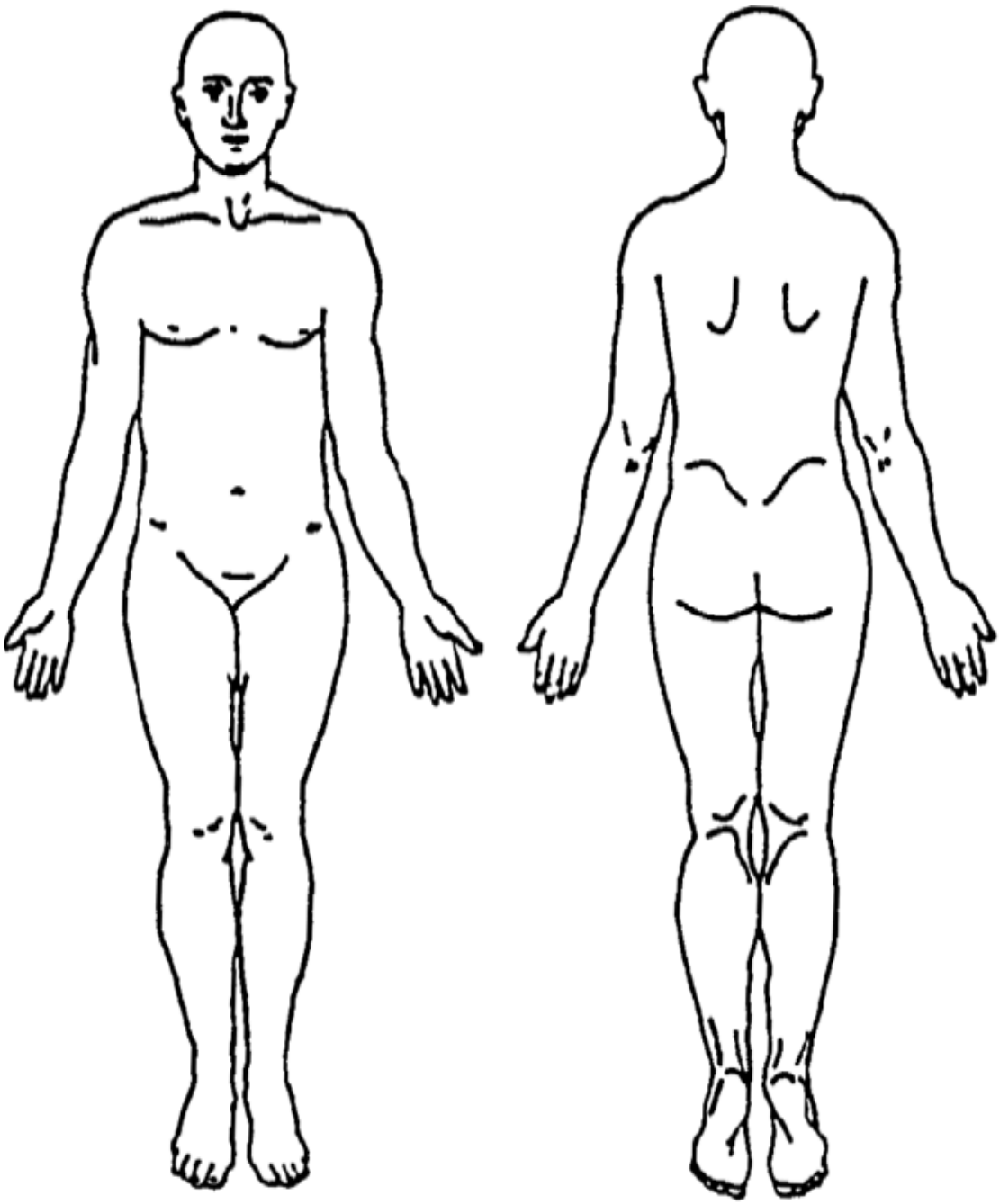
Circle the activities you feel you may do too much: Alcohol, Coffee/tea, soda, sugar candy, processed foods. Do you smoke? _____

TODAY'S PAIN INTENSITY RATING *(circle)*

0 _____ 1 ____ 2 _____ 3 ____ 4 _____ 5 ____ 6 _____ 7 ____ 8 _____ 9 ____ 10

No pain Severe Pain

Where is your pain? Use solid shading for most severe pain and slashes for (P) lesser pain or (S) sensory symptoms. Indicate if the sensory symptoms are (T) tingling or (B) burning in nature.



CURRENT / PAST MEDICAL CONDITIONS
(please indicate C for current or P for past where appropriate)

☐ Asthma	☐ Chronic Cough	☐ Sinusitis	☐ Headache/Migraines
☐ Whiplash/MVA	☐ Concussion/Falls	☐ TMJD	☐ Tinnitus/Ear Ringing
☐ Shortness of Breath	☐ Poor Balance	☐ Dizziness	☐ Hyperventilation
☐ Fainting	☐ Strength Changes	☐ Heart Disease	☐ Chest Pain/tightness
☐ Cardiac Arrhythmia	☐ Stroke/TIA	☐ Raynaud's	☐ Blood Clots
☐ Poor Circulation	☐ Anemia	☐ Easy Bruising	☐ Chronic Diarrhe
☐ IBS	☐ Incontinence	☐ Celiac Disease	☐ Reflux/Heartburn
☐ Stomach cramps	☐ Bloating	☐ Constipation	☐ Abdominal Pain
☐ Hernia	☐ Thoracic Outlet Syn.	☐ Rotator Cuff Pain	☐ Carpal Tunnel Syn.
☐ Frozen Shoulder	☐ Tennis/Golfer's Elbow	☐ Scoliosis	☐ Sciatica
☐ Osteoarthritis	☐ Rheumatoid Arthritis	☐ Osteoporosis	☐ Joint Stiffness
☐ Hypermobility	☐ Diabetes	☐ Night Cramps	☐ Cancer
☐ Fibromyalgia	☐ HIV/AIDS	☐ Chronic Fatigue /ME	☐ Thyroid Disorder
☐ Skin Diseases	☐ Skin sensitivities	☐ Weight loss/gain	☐ Excess Perspiration
☐ Chronically Cold	☐ Alcoholism	☐ Sleep Disorder	☐ Mental Illness
☐ Drug Abuse	☐ Depression	☐ Anxiety	☐ Mental Fogginess
☐ Stress at work	☐ Stress at home		

Please list all other medical conditions that you have (even if you are not seeking treatment for them here):

_____

_____

_____

FOR WOMEN

☐ Pregnancy ☐ Menstrual Pain ☐ C-Section ☐ Menopause

PATIENT MEDICAL AGREEMENT

_____ ("Patient") hereby agrees to the following:

1. An examination and treatment that may require the removal of some clothing articles, palpation (manual examination) of body part(s) and close observation of body part(s). I consent to treatment within my therapist's (OTR/L, CHT, CMTPT) scope of practice. I understand treatment will be discussed with me prior to its application and that at any time I have the right to refuse treatment. I acknowledge that no assurance or guarantee has been provided me as to the results of the treatment.

The therapist has provided me the opportunity to ask any questions I might have regarding the treatments, and answered those questions to my satisfaction. I hereby consent to the treatment. I understand I can revoke my consent and Karen Gallagher may terminate the patient relationship at any time upon adequate notice.

2. The fee schedule is as stated at sumofallpointspainrelief.com. Sum of All Points and Karen Gallagher do not participate in any third party insurance programs and will not submit health insurance claims on my behalf. By signing this agreement, I agree to be personally responsible for the fees described herein:

3. Privacy Notice and Medical Records: You acknowledge we have provided a Notice of Health Information Practices similar to HIPAA on our website and I acknowledge that I had the opportunity to review.

A. I authorize the following person(s) or class of persons to use and/or disclose the information:_____

B.. I authorize the following person(s) or class of persons to receive the information (i.e. doctors, family members: _____

C. I authorize the release of all of my medical information except as follows:
_____

Please indicate how we can best communicate with **you** concerning the following areas by checking the preferred methods of communication. Please note that the forms of communication other than portal email are less secure as other individuals could intercept the communication.

Patient appointment reminders:	_____ Text _____ Call on Cell _____ Home phone _____ Portal email	Health information:	_____ Text _____ Call on Cell _____ Home phone _____ Portal email

_____ _____
Signature of Patient Date

_____ _____
Patient's Name (Print) Date of Birth