NEW DAY
MYOPAIN CENTER

NAME: _____ Today's Date: _____/_____/_____

How did you hear about us? _____

Address: _____

_____

Phone (Preferred): _____ is this a mobile phone?

Email: _____

Appointment reminders, occasional marketing specials and newsletter

by email okay? _____Yes _____No

(We agree not to share or sell your information.)

Date of Birth: _____

Occupation: _____

Have you had a professional massage before? _____Yes _____No

Informed Consent:
I recognize that myofascial trigger point therapy and therapeutic massage can be legally provided in the commonwealth of Kentucky without a physician's referral. By signing this document, I assume all risk for my health and wellbeing and hold harmless any responsibility New Day Myopain Center or any persons involved with this program.

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

I have discussed my own physical limitations and/or suspected health concerns with New Day Myopain Center and Amber Davies.

Signature: _____ Date: _____

For Internal Use: Photo on file: _____ Online Scheduling: _____ iCloud contacts: _____ Rate: _____

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Health History Form

Name: _____ Today's Date: _____/_____/_____

Please describe the reason you are seeking treatment. Give a **brief history** including when symptoms began:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Is your pain ***worse*** when _____ sitting _____ standing _____ walking _____ sleeping?

List ***other things or activities*** that make your pain ***worse***:

_____
_____
_____

List ***things or activities*** that *make your pain* ***better***:

_____
_____
_____

List all **diagnostic tests** you have had (and results) for your current pain/condition:

_____
_____
_____

What **other treatments** have you tried? What **results** did you have?

_____
_____
_____

What would you like to achieve in treatment here?

_____
_____
_____

What is your **regular exercise**?

_____
_____

What are your **exercise goals**?

_____
_____

How do you use your body during the average day including all work and activities? Habits or hobbies? Are you sitting a lot during the day? Do you play an instrument, walk a dog, carry heavy loads, do small detailed work? **What about in the past**? Any musical instruments or sports for a long period?

_____
_____
_____
_____

Are you currently working? _____ No _____ Full-Time _____ Part-Time
Did you work before your symptoms began? _____ Yes _____ No
Did your pain cause you to stop working? _____ Yes _____ No

List Current Medications and/or Supplements (spelling doesn't count!)

Taking_____	for_____	Taking_____	for_____
Taking_____	for_____	Taking_____	for_____
Taking_____	for_____	Taking_____	for_____
Taking_____	for_____	Taking_____	for_____
Taking_____	for_____	Taking_____	for_____

Are you aware of having or have you been diagnosed as having any of the following conditions or symptoms? If so, please indicate **"C" for current** or **"P" for past** where appropriate.

Asthma	_____	Abdominal Pain	_____	Cancer	_____
Chronic Cough	_____	IBS	_____	Stroke	_____
Allergies	_____	Bloating	_____	Blood clots	_____
Migraines	_____	Chronic Diarrhea	_____	Hypertension	_____
Memory Loss	_____	Constipation	_____	Hypotension	_____
Depression	_____	Food Allergies	_____	Diabetes	_____
		Chronic Sinusitis	_____	Angina	_____
Fibromyalgia	_____				
Chronic Fatigue	_____	Intra-Pelvic Pain	_____	Osteoporosis	_____
Thyroid Disorder	_____	Chronic Prostatitis	_____	Arthritis (diagnosed)	_____
Auto Immune	_____	Chronic Vulvodynia	_____	Structurally Short leg	_____
Chronically Cold	_____			One foot much bigger	_____
Sleep Disorder	_____	Painful Urination	_____	Orthotics	_____
Sleep Apnea	_____	Urinary Frequency	_____	Heel Lift	_____
		Urinary Urgency	_____		
TMJD	_____	Stress Incontinence	_____	Scoliosis	_____
Tinnitus	_____			Strength Changes	_____
Clench/Grind	_____	Painful Defecation	_____	Reduced Range of Moti on	_____
Dental Problems	_____	Pregnancies	_____	Hypermobility	_____
Dizziness	_____	Menstrual Pain	_____		
Fainting	_____	Menopause	_____	Vision Changes	_____
Seizures	_____	Hormone Replacement	_____	Glasses	_____

Please list ***all*** **other health conditions** that you have:

_____

_____

_____

_____

_____

List all surgeries (including cosmetic) and approximate date or age you were:

_____

_____

_____

_____

List all **past injuries** and approximate date or age you were:

_____

_____

_____

_____

Do you have TMJD Syndrome? _____ Yes _____ No
Do you clench or grind your teeth? _____ Yes _____ No
Do you wear a night guard or mouth splint? _____ Yes _____ No
Did you have braces? _____Yes_____No
Do you have jaw pain associated with chewing or yawning? _____ Yes _____ No
When was your last dental appointment? _____
When was your last eye exam? _____
Do you wear bifocals/trifocals? _____ Yes _____ No
Do you wear orthotics in your shoes? _____Yes _____ No
Do you wear a heel lift in one shoe to make your leg longer? _____Yes _____ No
Are you: _____ Right Handed _____ Left Handed _____ Both
What is your approximate current: Height _____ Weight _____

I watch _____ hours of TV per day.
I spend _____ hours playing video games, computer games or surfing the web.
I commute _____ minutes/hours to and from work each day.
I smoke _____ cigarettes, cigars, pipes per day. I used to smoke but quit _____ ago.
I use _____ e-cigarettes? How much/often? _____
I drink _____ cups of coffee/tea/caffeinated beverage per day.
I drink _____ alcoholic beverages per day.
I drink _____ glasses of non-caffeinated fluid per day. How much is water?
I chew _____ sticks of gum per day.

I sleep _____ hours per night.
I go to sleep at _____ and wake up at _____.
I have trouble _____ falling asleep _____ staying asleep _____ waking up.
My sleep quality is _____ great _____ good _____ poor.
I sleep on my _____ back _____ stomach _____ side.
I get up to go to the bathroom _____ times per night.
When I wake up I feel _____ well rested _____ still tired.
I have _____ sleep apnea _____ insomnia _____ uncomfortable bed.

Signature: _____ Date:_____