Myofascial Wisdom

Client Intake and Agreement Form

It is my choice to receive Myofascial Release and Massage Therapy. By signing below I,_____, waive and release my therapist of any liability, past, present and future and I give my consent to receive treatment. I acknowledge that my therapist is not a medical doctor and that Massage Therapy and Myofascial Release is not a substitute for medical care, medical examination or diagnosis. In this form, I have stated all medical conditions that I am aware of and will inform my therapist of any changes in my health status should they occur. I will not hold my therapist liable should I forget to inform her of those changes.

SIGN_____ DATE_____

Name
_____
Address
_____
City State Zip
_____
Home phone Cell phone
_____
Email
_____
Occupation
_____
Emergency contact name and phone
_____

How did you hear about me?
_____
Have you had professional bodywork before?
Yes No
What types? (i.e. massage, shiatsu, reiki)
_____
If so, how long have you been receiving bodywork and how frequently?
_____
Have you had Myofascial Release (MFR)?
Yes No
If yes, was it the John F. Barnes' approach to MFR?
Yes No Not sure

~The information you provide in this form will help me better serve you and increase the effectiveness of our work together. Thank you for providing specific information about your health history, current symptoms and goals for treatment. If you need more space for details, use the back of the sheet.~

Please describe in detail your primary reason for coming to see me for Myofascial Release…

_____

_____

Do you have a secondary reason? Please describe…

_____

_____

HOW and WHEN did your symptoms begin? For example, are they trauma induced or because of an accident or surgery? Or, because of an unknown reason? Please describe…

_____

_____

Are you currently seeing a doctor or other health professional concerning these symptoms? Yes No
If yes, please give details about who you are seeing, when you started and what treatment you are receiving, how long you have been receiving treatment and how effective it has been…

_____

_____

_____

If you are experiencing pain or discomfort how would you rate your level of sensation? 1 being the lowest, 10 being the highest level…

1 2 3 4 5 6 7 8 9 10

Are there activities that increase your discomfort or pain? Please describe…

_____

Are there activities that decrease your discomfort or pain? Please describe…

_____

Are you willing to commit to a series of Myofascial Release treatments to address your symptoms?
Yes No Not sure

Please tell me your ultimate goal for receiving Myofascial Release Therapy. For example, are there activities that you would like to return to and/or any other goals…

_____

_____

Do you exercise or participate in any sports? Please list frequency and type…

_____

Do you perform any repetitive movements in your work, sports, or hobbies? Please list…

_____

How do you rate your level of mental/emotional stress? 1 being the lowest 10 being the highest

1 2 3 4 5 6 7 8 9 10

List all current and historical injuries and surgeries with dates these occurred. If you need more room, use the back of this sheet…

Date_____ Discription_____

Date_____ Discription_____

Date_____ Discription_____

Date_____ Discription_____

Date_____ Discription_____

Date_____ Discription_____

List all medications you are currently taking or applying topically and supplements/herbs you use, and the reason you are taking them. If you need more room, use the back of this sheet…

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

Do you have sensitive skin? Yes No

Are you allergic to nuts, oils or lotions? Please describe…

_____

Do you have chemical sensitivities or allergies? Please describe…

_____

Mark any current conditions with a "C" and any past conditions with a "P"

___ Bone or joint disease	___ Breathing difficulty/asthma	___ Bladder/kidney ailment
___ Tendonitis/bursitis	___ Emphysema	___ Colitis
___ Arthritis/Gout	___ Sinus problems	___ Crohn's disease
___ Jaw/TMJ pain	___ Rashes	___ Ulcers
___ Fracture	___ Cosmetic Surgery	___ Abdominal hernia
___ Spinal problems	___ Herpes/cold sores	___ Pregnant, stage_____
___ Migraines/headaches	___ Heart Conditions	___ Anxiety/stress syndrome
___ Osteoporosis	___ Phlebitis/Varicose Veins	___ Depression
___ Shingles	___ Blood clots	___ Lupus
___ Numbness/tingling	___ Stroke	___ Rheumatoid arthritis
___ Chronic pain	___ High/low blood pressure	___ Cancer/tumors
___ Paralysis	___ Lymphedema	___ Diabetes
___ Multiple Sclerosis	___ Thrombosis/embolism	___ Drug/alcohol/tobacco use
___ Parkinson's Disease	___ Hematoma	Any other medical conditions
___ ALS	___ Aneurysm	not listed:_____
	___ Irritable bowel syndrome	_____

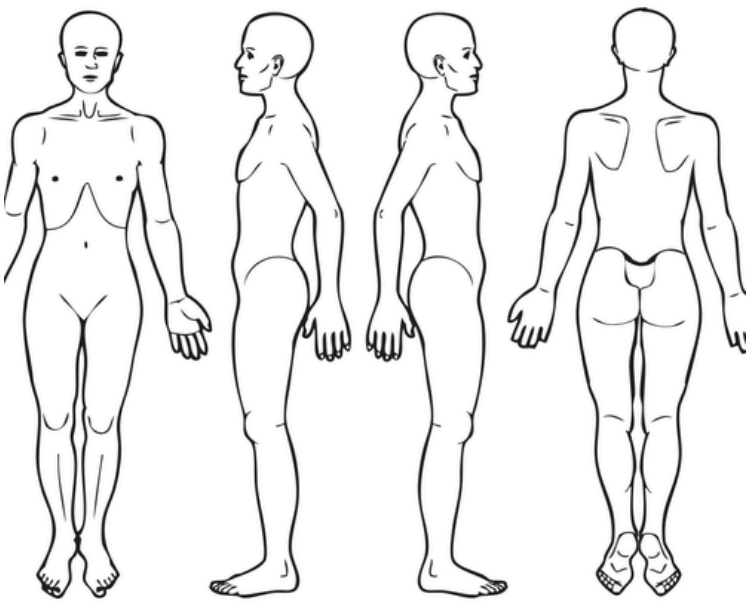
Please shade in areas of pain or other symptoms on the figures to the right. If there is anything else you would like me to know about your physical symptoms, please explain here:

_____

_____

_____

_____



By signing below, I verify that all information I have provided on these forms is true, accurate and complete.

SIGN_____ DATE_____

Myofascial Release (MFR) and Massage Therapy Detailed Informed Consent Form

Thank you for taking the time to read this document thoroughly. If any questions or concerns arise they can be addressed during treatment time.

Please initial each line after reading it.

1. _____ I understand that the John F Barnes approach to MFR therapy will never injure me.
2. _____ I understand that the following conditions are contraindicated for MFR either locally or otherwise. It is my responsibility to inform my therapist if I am currently experiencing any of these conditions:

Fever (above 100 degrees) Broken bones (local to the area) Hernias repaired with mesh (local to the area) Pregnancy (over the abdomen) Flare up of an autoimmune condition (local to the area)	Broken or damaged skin (local to the area) Blood clots (local to the area) Aneurysm (local to the area) Thrombosis/Embolism (local to the area)

3. _____ I understand that I may experience pain, discomfort, a healing crisis or other associated sensations after treatment, and that those experiences can be a part of the healing process.
4. _____ I understand that rarely does one treatment completely resolve the symptoms I may be experiencing and that continuing MFR therapy is often necessary to help with the continued reduction of fascial restrictions in my system. Restrictions can be reduced by home self care and continued treatment.
5. _____ I understand that MFR and Massage Therapy are NON-sexual.
6. _____ I understand that MFR therapy must be performed with skin to skin contact and that my therapist may use hands, forearms and elbows to administer treatment.
7. _____ I understand that it's possible to experience emotions, past traumas/experiences while being treated and possibly afterward due to the mental/emotional holding patterns in restricted areas of fascia.
8. _____ I understand that my practitioner is not a medical doctor and does not provide medical diagnosis or medical examination.

I, _____, understand all of the information stated in this form and by signing below verify that understanding.

Sign _____ Date_____

Lorien Caldwell LMT

Things to know for your Myofascial Release (MFR) treatment:

1. Do not apply any lotions or oils after cleansing your skin before treatment. Any glide on the skin greatly decreases the effectiveness of the techniques.
2. Effective MFR requires access to your skin for hands on technique and assessment. For treatment garments:
   Women: athletic shorts and a sports bra OR a two piece bathing suit. You may also wear a tank top.
   Men: athletic shorts or a bathing suit.
3. I know some of us like to chit chat! However, during treatment it is best to settle into your body without too much talk. This is your time to tune in, connect and feel your body and will make the MFR effective. Your therapist will only talk to you if it is necessary or beneficial to the therapy.
4. Restrictions in fascia can at times be painful. Your fascia is strong and can exert up to 2,000 pounds per square inch! While therapeutic pain can be a part of releasing, experiencing intense pain does NOT mean you are benefiting. Excessive pain causes your fascial system to tighten down more, resulting in the opposite effect. Listen to what your body needs. To lessen the pressure from your therapist, please say the words “ease up”. If you would like to stop therapy please say “halt”. We use these words “ease up” and “halt” in MFR as an easy way to communicate. You will always be listened to and respected.
5. MFR accesses the whole body system that encompasses every other system of your body right down to the cellular level. There is a superficial layer of fascia under your skin that flows in a three dimensional web through your body connecting your head to your toes without beginning or end. It is most often necessary to treat areas other than the one you are currently experiencing issues. While receiving, you can at times feel sensations in other areas. We call this the “fascial voice”. You may also experience sensations in different areas after treatment.

Print your name_____

Sign your name_____ Date_____

Notice of Privacy Practices

The massage therapist is allowed to use and disclose Patient Health Information without patient consent only for routine health-care purposes — treatment, payment and healthcare operations. For non-routine uses, such as marketing, fundraising and most research, the massage therapist must obtain prior specific patient authorization. Patient has the right: (1) to access their Patient Health Information; (2) to request that their Patient Health Information be amended; (3) to request that the use of their Patient Health Information be restricted; (4) to request alternative means of communications; and, (5) to complain about an entity's Patient Health Information protection procedures without fear of reprisal.

Do you give Myofascial Wisdom permission to use your information such as email address or phone number for marketing purposes? Your personal information will never be sold or given to any other entity.
Please circle one:

Yes No

May Myofascial Wisdom contact you with updates on your appointments and important information pertaining to your care?
Please circle one:

Yes No

Acknowledgement of receipt of Notice of Privacy Practices:

Signature of Patient: _____

Printed Name of Patient: _____

Date: _____

Practitioner Signature: _____

Appointment cancellation, late or missed appointments and general policies

Please read thoroughly and sign below.

Any appointment that is not canceled with at least a 48 hour notice will incur a charge for the full amount of the appointment with the credit card on file. There will be no option to reschedule to avoid being charged. You will need to schedule another appointment for the full amount.

Any missed appointment or no-show will incur a charge for the full amount of the appointment with the credit card on file. There will be no option to reschedule to avoid being charged. You will need to schedule another appointment for the full amount.

If you show up late to your appointment you will be charged for the full amount of the appointment and will receive treatment until the original scheduled end time. You will not receive extra time for your treatment.

The massage therapist reserves the right to dismiss patients for inappropriate conduct, non or late payment of fees, medical reasons, safety concerns and other as determined by the therapist.

Payment for an appointment is required at the time of your visit. Returned checks will incur a $25.00 fee, due and payable immediately. Any product purchased must be paid in full at time of service and is non refundable. Insurance is not accepted and it is the sole responsibility of the patient to receive reimbursement from their carrier. Any documents will be provided after payment is received.

I have reviewed, understood and agree to abide with the office policies as stated above.

Sign_____ Date_____

Code of Ethics

MFR and Massage therapists shall:

1. Demonstrate commitment to provide the highest quality Myofascial Release and Massage Therapy to those who seek their professional service.

2. Acknowledge the inherent worth and individuality of each person by not discriminating or behaving in any prejudicial manner with clients and/or colleagues.

3. Demonstrate professional excellence through regular self-assessment of strengths, limitations, and effectiveness by continued education and training.

4. Acknowledge the confidential nature of the professional relationship with clients and respect each client's right to privacy.

5. Conduct all business and professional activities within their scope of practice, the law of the land, and project a professional image.

6. Refrain from engaging in any sexual conduct or sexual activities involving their clients.

7. Accept responsibility to do no harm to the physical, mental and emotional well-being of self, clients, and associates.