Client Intake Form

The information requested below is critical to assist us in providing you the best and safest treatments and will help us better serve you and increase the effectiveness of our work together. Please be honest, accurate, and thorough. Please ask your therapist if you have any questions about the information being requested. All information provided below will be kept confidential unless required by law.

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

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

Do you have a secondary reason? Please describe…

How 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…

When did your symptoms begin?

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…

Regardless of any diagnosis you might have received, please explain in your words what you think the problem is…

_____

_____

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…

_____

What activities are you missing out from now because of your condition and why?

_____

How often is your condition interfering with your normal functioning?

_____

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

How has your condition affected your life?

_____

_____

Why is now the perfect time to get help with this?

_____

_____

Do you believe you can get better?
Yes No Not sure

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…

_____

_____

List all current and historical surgeries with dates these occurred.

Date_____ Discription_____

Date_____ Discription_____

Date_____ Discription_____

Date_____ Discription_____

Date_____ Discription_____

Date_____ Discription_____

Do you have any implants? (e.g. pacemaker, insulin pump, metal) What implants and when were they installed?

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.

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

Are you currently under medical supervision or receiving other medical interventions? If yes, please describe:

_____

Have you had any car accidents, significant injuries or trauma in the past? If so, please list accident or injury and approximate time frame:

Date_____ Discription_____

Date_____ Discription_____

Date_____ Discription_____

Date_____ Discription_____

Date_____ Discription_____

Date_____ Discription_____

Do you have sensitive skin? Yes No

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

_____

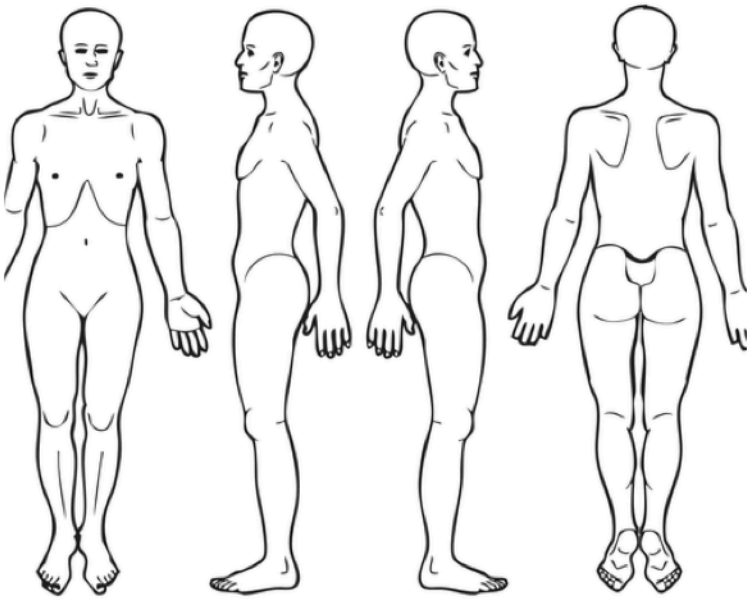
Do you have chemical sensitivities or allergies? Please describe…

_____

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.



Is there anything else you haven't mentioned that would be useful for your MFR therapist to know?

_____

_____

_____

_____

_____

By signing below, you verify that all information you have provided on these forms is true, accurate and complete. You agree that if your health status should change, you will notify your therapist immediately.

Client's signature_____ DATE_____

Therapist's signature_____DATE_____

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

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

1. The John F Barnes approach to MFR therapy will never injure.
2. The following conditions are contraindicated for MFR either locally or otherwise. It is the patient's responsibility to inform the therapist if they are 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. The patient may experience a stirring up of symptoms, discomfort, a healing crisis or other associated sensations after treatment, and those experiences can be a part of the healing process.
4. Rarely does one session completely resolve symptoms. Healing is a process and not an event. Continuing MFR therapy is often necessary to fully resolve issues. Restrictions can also be reduced by home self care.
5. MFR therapy is non-sexual.
6. MFR therapy is best performed with skin to skin contact and the therapist may use hands, forearms and elbows to administer treatment.
7. 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. The 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. In the understanding of this information, I give my consent to receive treatment.

Sign _____ Date_____