S.A.M.I. Myofascial Release

Client Intake Form

Name _____

Email _____

Phone _____

Date of Initial Visit _____

1. Have you had myofascial release with a different practitioner before? Yes No

   If yes, please list the date(s) and location(s) of prior visits. For each visit, please describe the area(s) and result(s).

   _____

2. Are you currently under the care of a physical therapist? Yes No

3. Do you perform any repetitive movement(s) in your work, sports, or hobby? Yes No

   If yes, please describe _____

4. Reason behind today's visit:

5. Referral source:

The following is your medical screening form, to be completed prior to your first session, and to be reviewed and updated by you prior to each subsequent session. Please initial and date any updates made after your first visit.

All information will be kept in accordance with our Notice of Privacy Practices. This information will be used for the evaluation of your health and readiness to begin our program. The form is extensive, but please try to make it as accurate and complete as possible. Please take your time and complete it carefully and thoroughly, and then review it to be certain you have not left anything out. Your answers will help your practitioner design a comprehensive program that meets your individual needs.

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Medical Screening

Emergency contact: Name:
Phone Number:

Current Medical History

Do you now have or have you recently (within the past 6 months) experienced: (Mark all that apply)

- Chronic, recurrent or morning cough?
- Increased anxiety or depression?
- Problems with recurrent fatigue, trouble sleeping or increased irritability?
- Fever, migraine, or recurrent headaches?
- Swollen or painful knees or ankles?
- Swollen, stiff or painful joints?
- Pain in your legs after walking short distances?
- Other?_____

Are you currently taking any medication (prescription or over the counter), herbal supplements, or vitamins? Yes No

If yes, please list.

Do you have any allergies? Yes No

If yes, please list.

Family Physician and/or Primary Health Care Provider:

Name:

Phone Number:

Past Medical History

Check those questions to which your answer is yes (leave others blank).

- Heart attack if so, date? _____
- Rheumatic Fever
- Heart murmur
- Disease(s) of the arteries
- Other_____

Have you had any medical operations of any kind? Yes No

If yes, list and provide date(s).

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Is there anything else about your health history that you think would be useful for your practitioner to know to plan a safe and effective session?

Please mark your discomfort (please place an X on the area or circle)