VanNess

Chiropractic • Massage • Rehabilitation

Myofascial Release Intake Form- CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name_____ Date of birth_____
Address_____
State_____ City _____ Home Phone_____
Work Phone _____ Occupation _____
Have you ever received massage therapy? _____ Yes _____ No
Type of massage experienced (Swedish, shiatsu, deep tissue, etc.) _____
Are you currently taking any medications? _____ Yes _____ No
If yes, please list name and reason for medications_____
_____
_____
Are you currently seeing a healthcare professional? _____ Yes _____ No
If yes, please list names and reason/treatment _____
_____
_____

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

____ arthritis
____ diabetes
____ blood clots
____ broken/dislocated bones
____ bruise easily
____ cancer
____ chronic pain
____ constipation/diarrhea
____ auto-immune condition*
____ communicable diseases
____ muscle strain/sprain
____ skin conditions
____ s.t.d's
____ stroke
____ surgery
____ TMJ disorder
____ depression, panic disorder, other psych. condition
____ diverticulitis
____ back problems
____ heart conditions
____ headaches
____ high blood pressure
____ hepatitis (A, B, C, other)
____ herpes
____ insomnia
____ pregnancy
____ scoliosis
____ shingles
____ seizures
____ whiplash
____ chemical dependency (alcohol, drugs)

(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs to be detailed or if there is anything else to share, please do so:

_____
_____

Do you have any of the following today:

_____ skin rash _____ cold/flu _____ open cuts _____ severe pain
_____ anything contagious _____ injuries/bruises

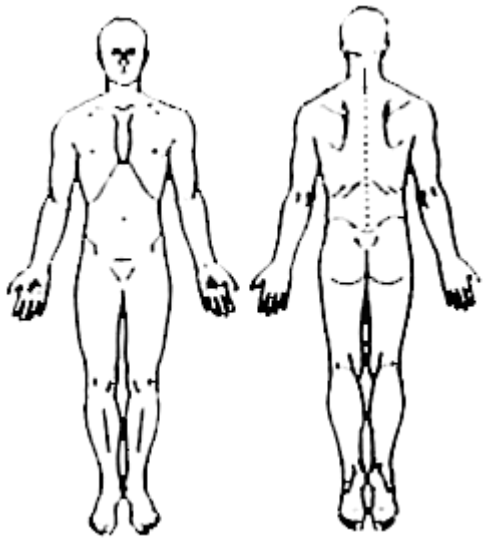
Do you have any allergies to:

_____ medications _____ foods (nuts, etc.)
_____ environmental allergens (dust, pollen, fragrances)
_____ reactions to skin care products

If any of the above are checked, please give details: _____
_____

Are you wearing: ____ contact lenses _____ hearing aid _____ hairpiece

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session? _____
_____

The following sometimes occurs during myofascial release.
Trust your body to express what it needs to:
Need to move or change position * Sighing, yawning, change in breathing
Stomach gurgling * emotional feelings and/or expression
Movement of intestinal gas * energy shifts * falling asleep * memories

Please read the following information and sign below:

1. I understand that myofascial release can be therapeutic, reduce muscular strain and scar tissue, it is not a substitute for medical examination, diagnosis, and treatment
2. Being that myofascial release should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: _____ Date_____