Introduction to Myofascial Release

Name:_____Date:_____

Address:_____Age:_____

City:_____ State: _____Zip Code:_____

Telephone #: ( )_____ E-Mail address: _____

If you give us your e mail, we will send you periodic notifications of fun events!
However all your information is completely confidential.

How did you hear about us?_____

Date of injury: _____Date symptoms began:_____

Please list medical history/surgeries/medications/past therapy: _____

_____

What is your primary complaint?_____

What is your secondary complaint?_____

Which activities aggravate your symptoms?_____

Which activities decrease your symptoms?_____

Please state your goals in utilizing this specialized therapy: _____

_____

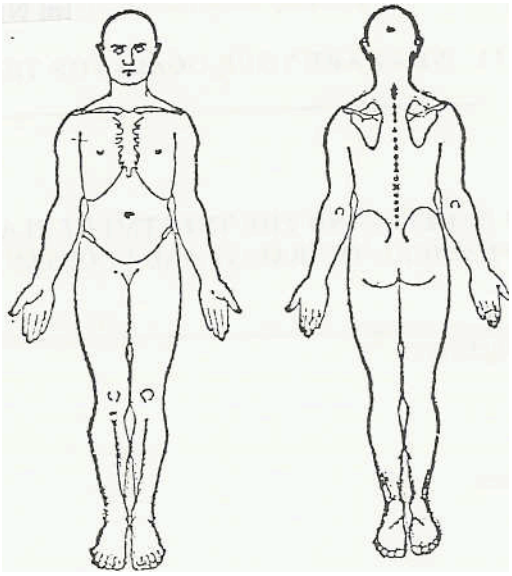
As with any bodywork, if the therapist is not providing you what you want, please offer suggestions. We want to make this a pleasurable and meaningful experience tailored especially for you.

Please be advised that the by signing below you agree and consent to this introductory session of evaluation and treatment (if indicated) using Myofascial Release.

_____ _____

Signature Date

Please shade below where your areas of PAIN/TIGHTNESS or other symptoms are:



Therapist's note:

Subjective: _____

Objective findings: _____

_____

_____

Type of treatment performed:_____

_____

Assessment after the treatment and recommendations: _____

_____

Time spent: ½ hour 1 hour 1-1/2 hours 2 hours

_____
Therapist's signature