Studio One SomaYoga & Massage – Bagley MN
John F. Barnes Myofascial Release Technique
Patient Intake Form

This form includes client intake and medical history information, as well as consent to receive treatment.

Your Personal Details

Today's date_____
Name_____ Date of birth_____ Age_____
Address_____ Occupation _____
Phone/Home _____ Mobile _____ Email_____
How referred _____

Emergency Contact:
Name_____
Relationship_____
Phone_____

Primary Care Physician:
Name_____
City/State_____
Phone_____

Medical History (Include Dates)
Surgeries and procedures:

_____
_____

Fractures_____
Accidents_____
Current medications (prescription and over-the-counter) and alternative supplements:

_____
_____

Have you been referred for further investigation, outpatient therapy, physiotherapy or other therapy by your general practitioner? If so, for what and when?

Health Problems: Do you have, or have you ever had, any of the following conditions? (Check all that apply.)

□circulatory disorder	□epilepsy	□osteoporosis or osteopenia
□respiratory disorder	□diabetes	□nervous system disorder (MS, stroke)
□heart condition	□abdominal complaints	
□high/low blood pressure	□skin disorder	□headaches
□thrombosis	□bowel complaints	□tinnitus (ringing in ears)
□dizziness	□bladder complaints	□blackouts
□dental complaints	□visual disturbance	□eating disorder
□varicose veins	□arthritis	□a potentially fatal condition
□cancer	□back/neck problems	□TMJ disorder

□allergies/sensitivities□Fibromyalgia□pregnant? (If yes, how many months?__)
□open sores or wounds

General

Height_____ Weight _____ Special diet_____
Smoker? Yes no If yes, how many per day?_____
How much water do you drink? _____ per day.
Alcohol consumption light moderate heavy

Sport, exercise, and relaxation_____
How would you describe your stress levels? High moderate low

Past traumas (emotional or physical)

_____

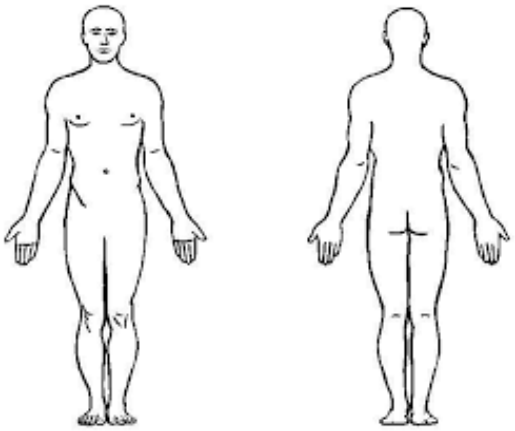
Your Reasons for Treatment

What are your expectations of this
treatment?_____

_____

_____

Primary Reason for Receiving Treatment
What is our primary complaint?_____
When and how did this complaint start? _____
How does this complaint affect you? _____
Is this a recurrence of an old injury? Yes no
If yes, when did the old injury occur? _____
Indicate your current level of discomfort (10 is worst) 0 1 2 3 4 5 6 7 8 9 10
Indicate the worst level of intensity you have had with your primary complaint:
0 1 2 3 4 5 6 7 8 9 10
When did the worst level of intensity occur? _____
What, if anything, increases your pain and discomfort? _____
What, if anything, decreases your pain and discomfort? _____
How often does your pain or discomfort occur on a normal day? (10 is constant & 0 is never)
0 1 2 3 4 5 6 7 8 9 10
At what time of day is your pain or discomfort at its worst? (Circle those that apply.)
on waking middayevening before bed during the night
To what extent (percentage) is your daily functional ability hindered as the result of our pain or discomfort? (Circle where 0% is the worst and 100% is the best.)
On a good day (percent): 0 10 20 30 40 50 60 70 80 90 100
On a bad day: 0 10 20 30 40 50 60 70 80 90 100
Have you had any previous treatment for this complaint? If so, what was it and what was the outcome?
_____
Have you had any x-rays, tests, or MRIs? If so, what were the results: yes no
_____
If you are employed, how many days have you been absent from work for this pain or discomfort?
_____
Indicate any other information that you think is relevant to our symptoms and treatment of your primary complaint. _____



Shade on the diagram the areas where you feel your pain or discomfort. Mark on the diagram with a cross (x) where you feel areas of numbness or tingling.

Other reasons for receiving treatment
Do you have any additional reasons for seeking treatment? _____
Summarize any previous or ongoing treatments or physician referrals for your secondary complaint, including appropriate dates and outcomes.

_____
Indicate any other information that you think is relevant to your symptoms and treatment of your secondary complaint._____
Have you at any time had treatment for a dental or jaw issue including wearing a mouth guard, braces, dental bridge or dentures? _____

Consent for Treatment and Physical Examination
Thank you for providing us with information on your medical status and your personal details. An MFR treatment consists of a discussion concerning general medical information and specific information regarding your present complaint, after which a physical examination will be carried out. This will include an in-depth assessment of our presenting complaint as well as any other relevant examination procedures. You will be required to change down to your underwear, or if you prefer, shorts and a bra top. During treatment you will be draped with sheets or towels.

On subsequent treatments, further assessments will be carried out to establish changes to your posture and function and presenting complaints.

Children will not be treated without a parent or guardian's permission.

Signature of client_____ Date_____

Signature of therapist _____ Date_____