MFR Journey Client History Disclosure Form

Name: _____ Date of Birth: _____

Address: _____ Age: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

E-Mail: _____ Occupation:_____

Referred By: _____ Currently Working: Yes No F/T P/T

Briefly describe condition(s) motivating you to seek Myofascial Release treatment: _____

_____

_____

_____

When and how did your symptoms begin? _____

_____

_____

_____

Secondary complaint? _____

_____

WHAT ARE YOUR GOALS FOR THERAPY: _____

_____

_____

Are you currently pregnant or is there even a possibility you may be pregnant? _____

Do you have a pacemaker, internal defibrillator, insulin pump or any other implanted medical device?

_____

List past medical history with dates for all surgeries, accidents and other traumas: _____

_____

_____

_____

_____

_____

Please list all prescription medications you are presently taking & reason for medication: _____

_____

_____

_____

_____

_____

Do you have any skin or medication allergies? Yes ___ No ___ If so which? _____

_____

Do you wear Contact Lenses? Yes ___ No ___

Dentures? Yes ___ No ___ Daily water consumption: _____

Do you currently exercise and/or participate in any sports? Yes ___ No ___

Do you experience any discomfort, shortness of breath or pain with these activities? Yes ___ No ___

In general, how would you characterize your lifestyle?

1	2	3	4	5	6	7
Active			Average			Inactive

HEALTH HISTORY

Mark the following conditions that apply to you, past and present. Please add your comments to clarify the condition. X = Now O = Past

___Headaches / Migraines
___Joint stiffness/swelling
___Spasms/cramps
___Broken/fractured bones
___Strains/sprains
___Back or neck pain
___Shoulder pain
___Tightness of throat
___Arm, hand pain
___Leg, foot pain
___Chest, rib pain
___Abdominal pain
___Problems walking
___Jaw pain/TMJ
___Tendonitis
___Bursitis
___Arthritis
___Osteoporosis
___Scoliosis
___HIV/AIDS
___Dizziness
___Chronic Infections
___Fainting
___Cold feet or hands
___Cold sweats
___Swollen ankles
___Varicose Veins
___Blood clots
___Stroke
___Heart condition
___High blood pressure
___Low blood pressure
___Hay Fever

___Rashes
___Allergies
___Dizzy / Vertigo
___Nervous stomach
___Indigestion
___Constipation
___Gas/bloating
___Diarrhea
___Concussion(s)
___Irritable bowel
___Sinus Problems
___Grinding of teeth
___Numbness/tingling
___Twitching of face
___Fatigue
___Chronic pain
___Sleep disorders
___Ulcers
___Paralysis
___Herpes/shingles
___Cerebral Palsy
___Epilepsy
___Hot flashes
___Multiple sclerosis
___Cancer
___Parkinson's disease
___Spinal cord injury
___Anemia
___Pregnancy
___Hemorrhoids
___Lymphedema
___Worrisome thoughts

___PMS
___Menopause
___Endometriosis
___Hysterectomy
___Fertility concerns
___Prostrate problem
___Loss of appetite
___Forgetfulness
___Confusion
___Depression
___Difficulty concentrating
___Water retention
___Anxiety about life
___Frequent urination
___Urinary leakage
___Painful urination
___Breast tenderness
___Common Colds
___Sore throat
___Eating disorder
___Diabetes (I or II)
___Fibromyalgia
___Chronic Fatigue Syndrome
___Aneurysm
___Earache or ringing in ears
___Eyestrain or discomfort
___Hepatitis / Liver Disease
___Gall bladder trouble
___Asthma or shortness of breath
___Thyroid Condition (hypo / hyper)
___Excessive alcohol abuse
___Other substance abuse
___Other _____

CONSENT FOR TREATMENT

Please take a moment to carefully read the following information and sign where indicated.

I understand myofascial release/bodywork may be contraindicated. A referral from my primary care physician may be required. I further understand that bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that is beyond the scope of practice of my massage therapist. I understand that massage/ bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because myofascial release/massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and have answered all questions honestly. I agree to keep my therapist updated as to any changes in my medical profile and understand there should be no liability on the part of the therapist should I forget to do so. It is also my understanding that any inappropriate or sexually suggestive remarks or misconduct made by me will result in immediate termination of the session, and I will be liable for the full payment of the scheduled appointment. I understand, I will be charged for appointments I cancel or miss without 24 hours notice of my scheduled appointment. I understand that if I arrive late I will receive the remainder of the time scheduled, but will be liable for payment in full.

Client Signature _____ Date _____

Signature of Parent or Guardian to treat a minor _____