Body Resonance Myofascial Wellness Center, LLC

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Client Information and Medical History Sheet

Name:	Today's date:
Address:	Phone #: Cell#:
City/State:	email:
Zip code:	Age: Date of birth: / /

Primary Care Physician:	Phone #:
Chiropractor / Acupuncturist / Dentist / Psychiatrist / PT	
circle any that are treating your current condition	

How did you hear about us? Who referred you?	

Married / Single / Divorced / Significant Other	
Work: FT / PT / Retired	Occupation:
Do you live: alone / with others who can assist you as needed	Primary Language: English / other: (name)
Do you have stairs in your home? Y N	
Are you are caregiver to: children / adult	
Emergency contact Name:	Phone:

Have you ever had physical therapy? How long?	Y N	What were you seen for?
Do you exercise regularly?	Y N	What activities?
Do you experience difficulties daily activities ?	Y N	Please list any:
Have you ever had massage therapy?	Y N	

Current Height: ft. ins	Is there any chance you are pregnant? Y N
Current Weight: lbs	

Do you take daily medications?	Y N	Please list:
Include any over the counter meds		
Do you get regular sleep?	Y N	Comment:
Do you smoke?	Y N	If yes, what amount?
Do you drink alcohol?	Y N	If yes, how frequent?
Do you have any allergies?	Y N	List:
Do you have any implants?	Y N	List:

Past medical history: mark X to any that apply

HIV?		Disease of the bones/ Osteoporosis?	
Cancer?		Disorders of the spine?	
Asthma?		Disease of the joints?	
Anemia?		Rheumatoid arthritis?	
Diabetes?		Disorders of the muscles?	
Disorder of the reproductive system?		Long term steroid treatment?	
Diseases of the liver?		Multiple sclerosis?	
Diseases of the lungs?		Hernia?	
Diseases of the gastrointestinal system?		Seizures/Epilepsy?	
Diseases of the circulatory system?		Stroke?	
Diseases of the kidney?		Neurological disorders?	
Heart disease or heart surgery or pacemaker?		Do you bruise easily?	
Hypertension (high blood pressure)?		Vision disorders?	
Migraines/headaches?		Balance or vestibular disorders?	
Rheumatic fever?		History of a blood clot?	
History of broken bone?		History of any trauma?	

If you answered yes to any of the above, please note them in detail below:

Please list any surgeries or accidents you've had and include dates:

Family History: Has anyone (mother, father, brothers, sisters) had any of the following: mark X to any that apply

Heart Disease		Rheumatoid arthritis	
Diabetes		Stroke	
Hypertension (high blood pressure)		Cancer	

Why are you requesting to be seen by a Myofascial Release Therapist today?

Please give a brief history of your symptoms: include dates

Have you seen a physician for these symptoms? Y N What was the treatment? Include any testing performed.

Pain/Discomfort Assessment

Is the pain: constant / intermittent / only on movement? (circle one)

Rate the pain on a scale of 0-10 (10 being the worse pain)

0 1 2 3 4 5 6 7 8 9 10

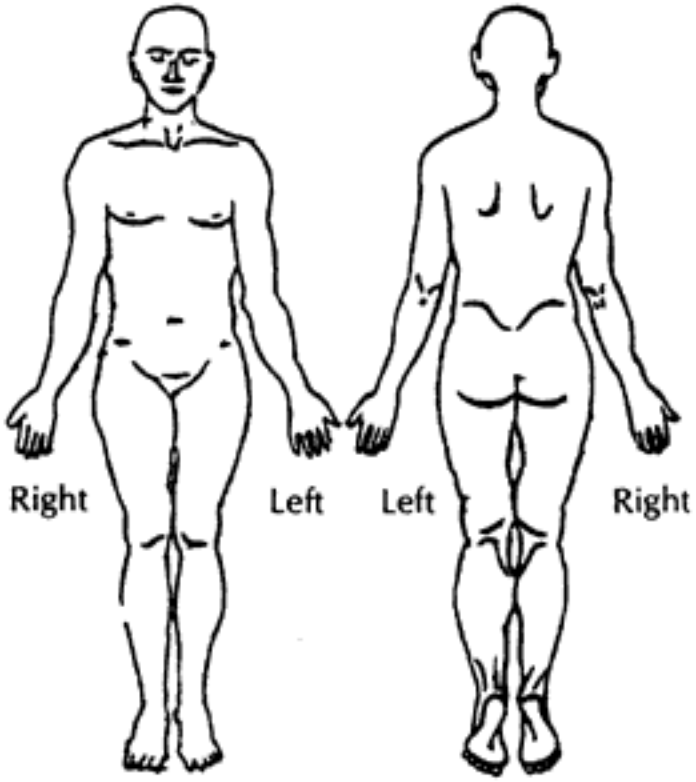
How would you describe your pain/discomfort:
Using the letter abbreviations label the diagram that best describes the type of pain or discomfort you have been experiencing:
N= Numbness T= Tingling D= Dull/aching P=Sharp B=Burning
S=Stiffness

Does the pain radiate? Y N If so, Where:_____

What activities make your pain better?_____

What activities make your pain worse?_____

Please indicate below by marking an X where you have pain or issues:



Cancellation Policy

I understand that each appointment I have is very important either for my own treatment process or that of another who could potentially fill the time slot. I agree to notify Body Resonance Myofascial Wellness Center within 24 hours if I need to cancel an appointment. If I am unable to do this, I understand that I will be responsible for payment for the scheduled time unless it is able to fill the appointment time.

I have read and understand this cancelation policy.

Signature _____ Date _____

Patient Privacy Practice

Your medical history, health care, and treatment are a private activity between you and the massage therapist, physical therapist and the staff that treat you. Your information will not be shared with any other party without your prior consent.

Please sign that you have read and understand this practice. Name any physician or significant other this information may be shared with.
Persons: whom I allow access to my information
Physician:_____

Significant Other name:_____

Your Printed name:_____ Date:_____

Signature:_____

Consent for the treatment of a minor:

I hereby authorize Rowena Cua, LMT/ Rosemarie Cua, PT, DPT to treat with Myofascial Release/massage/bodywork to my child or dependent as they deem necessary.

Name _____ Signature _____ Date_____