Client Intake and Agreement Form

It is my choice to receive Myofascial Release and Massage Therapy. By signing below I,_____, waive and release my therapist of any liability, past, present and future and I give my consent to receive treatment. I acknowledge that my therapist is not a medical doctor and that Massage Therapy and Myofascial Release is not a substitute for medical care, medical examination or diagnosis. In this form, I have stated all medical conditions that I am aware of and will inform my therapist of any changes in my health status should they occur. I will not hold my therapist liable should I forget or choose not to inform her of those changes.

SIGN_____ DATE_____

Name
_____
Address
_____
City State Zip
_____
Home phone Cell phone
_____
Email
_____
Occupation
_____
Emergency contact name and phone
_____

How did you hear about me?
_____
Have you had professional bodywork before?
Yes No
What types? (i.e. massage, shiatsu, reiki)
_____
If so, how long have you been receiving bodywork and how frequently?
_____
Have you had Myofascial Release (MFR)?
Yes No
If yes, was it the John F. Barnes' approach to MFR?
Yes No Not sure

~The information you provide in this form will help me better serve you and increase the effectiveness of our work together. Thank you for providing specific information about your health history, current symptoms and goals for treatment. If you need more space for details, use the back of the sheet.~

Please describe in detail your primary reason for coming to see me for Myofascial Release…

_____

_____

Do you have a secondary reason? Please describe…

_____

_____

HOW and WHEN did your symptoms begin? For example, are they trauma induced or because of an accident or surgery? Or, because of an unknown reason? Please describe…

_____

_____

Are you currently seeing a doctor or other health professional concerning these symptoms? Yes No
If yes, please give details about who you are seeing, when you started and what treatment you are receiving, how long you have been receiving treatment and how effective it has been…

_____

_____

If you are experiencing pain or discomfort how would you rate your level of sensation? 1 being the lowest, 10 being the highest level…

1 2 3 4 5 6 7 8 9 10

Are there activities that increase your discomfort or pain? Please describe…

_____

Are there activities that decrease your discomfort or pain? Please describe…

_____

Are you willing to commit to a series of Myofascial Release treatments to address your symptoms?
Yes No Not sure

Please tell me your ultimate goal for receiving Myofascial Release Therapy. For example, are there activities that you would like to return to and/or any other goals…

_____

_____

Do you exercise or participate in any sports? Please list frequency and type…

_____

Do you perform any repetitive movements in your work, sports, or hobbies? Please list…

_____

How do you rate your level of mental/emotional stress? 1 being the lowest 10 being the highest

1 2 3 4 5 6 7 8 9 10

List all current and historical injuries and surgeries with dates these occurred. If you need more room, use the back of this sheet…

Date_____ Discription_____

Date_____ Discription_____

Date_____ Discription_____

Date_____ Discription_____

Date_____ Discription_____

Date_____ Discription_____

List all medications you are currently taking or applying topically and supplements/herbs you use, and the reason you are taking them. If you need more room, use the back of this sheet…

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

Do you have sensitive skin? Yes No

Are you allergic to nuts, oils or lotions? Please describe…

_____

Do you have chemical sensitivities or allergies? Please describe…

_____

Mark any current conditions with a "C" and any past conditions with a "P"

___ Bone or joint disease	___ Breathing difficulty/asthma	___ Bladder/kidney ailment
___ Tendonitis/bursitis	___ Emphysema	___ Colitis
___ Arthritis/Gout	___ Sinus problems	___ Crohn's disease
___ Jaw/TMJ pain	___ Rashes	___ Ulcers
___ Fracture	___ Cosmetic Surgery	___ Abdominal hernia
___ Spinal problems	___ Herpes/cold sores	___ Pregnant, stage_____
___ Migraines/headaches	___ Heart Conditions	___ Anxiety/stress syndrome
___ Osteoporosis	___ Phlebitis/Varicose Veins	___ Depression
___ Shingles	___ Blood clots	___ Lupus
___ Numbness/tingling	___ Stroke	___ Rheumatoid arthritis
___ Chronic pain	___ High/low blood pressure	___ Cancer/tumors
___ Paralysis	___ Lymphedema	___ Diabetes
___ Multiple Sclerosis	___ Thrombosis/embolism	___ Drug/alcohol/tobacco use
___ Parkinson's Disease	___ Hematoma	Any other medical conditions
___ ALS	___ Aneurysm	not listed:_____
	___ Irritable bowel syndrome	_____

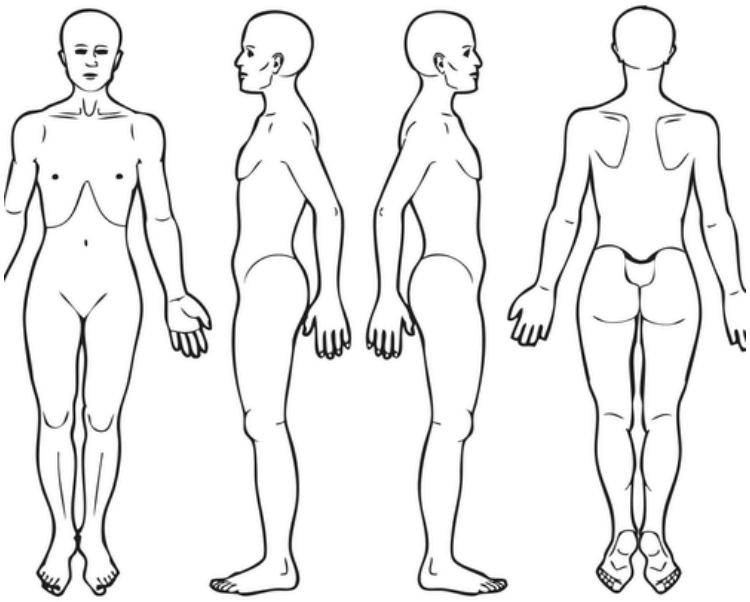
Please shade in areas of pain or other symptoms on the figures to the right. If there is anything else you would like me to know about your physical symptoms, please explain here:

_____

_____

_____

_____



By signing below, I verify that all information I have provided on these forms is true, accurate and complete.

SIGN_____ DATE_____

Myofascial Release (MFR) and Massage Therapy Detailed Informed Consent Form

Thank you for taking the time to read and sign this document. If any questions or concerns arise they can be addressed during treatment time.

1. The John F Barnes approach to MFR therapy will never injure.
2. The following conditions are contraindicated for MFR either locally or otherwise. It is the patient's responsibility to inform the therapist if they are experiencing any of these conditions.

Fever (above 100 degrees) Broken bones (local to the area) Hernias repaired with mesh (local to the area) Pregnancy (over the abdomen) Flare up of an autoimmune condition (local to the area)	Broken or damaged skin (local to the area) Blood clots (local to the area) Aneurysm (local to the area) Thrombosis/Embolism (local to the area)

3. The patient may experience a stirring up of symptoms, discomfort, a healing crisis or other associated sensations after treatment, and those experiences can be a part of the healing process.
4. Rarely does one session completely resolve symptoms. Healing is a process and not an event. Continuing MFR therapy is often necessary to fully resolve issues. Restrictions can also be reduced by home self care.
5. MFR and Massage Therapy are non-sexual.
6. MFR therapy is best performed with skin to skin contact and the therapist may use hands, forearms and elbows to administer treatment.
7. It's possible to experience emotions, past traumas/experiences while being treated and possibly afterward due to the mental/emotional holding patterns in restricted areas of fascia.
8. The practitioner is not a medical doctor and does not provide medical diagnosis or medical examination.

I, _____, understand all of the information stated in this form and by signing below verify that understanding. In the understanding of this information, I give my consent to receive treatment.

Sign _____ Date_____

Notice of Privacy Practices

Myofascial Wisdom PLLC is allowed to use and disclose Patient Health Information without patient consent only for routine health-care purposes — treatment, payment and healthcare operations. For non-routine uses, such as promotional, fundraising and most research, Myofascial Wisdom PLLC must obtain prior specific patient authorization. Patient has the right: (1) to access their Patient Health Information; (2) to request that their Patient Health Information be amended; (3) to request that the use of their Patient Health Information be restricted; (4) to request alternative means of communications; and, (5) to complain about an entity's Patient Health Information protection procedures without fear of reprisal.

Do you give Myofascial Wisdom permission to use your information such as email address or phone number for informational and occasional promotional purposes? With approval, you will receive notice of discounts and specials, price changes and Myofascial Release inspired informational emails. Your personal information will **never** be sold or given to any other entity.
Please circle one:

Yes No

May Myofascial Wisdom contact you with updates on your appointments and payment information pertaining to your care?
Please circle one:

Yes No

Acknowledgement of receipt of Notice of Privacy Practices:

Signature of Patient: _____

Printed Name of Patient: _____

Date: _____

Practitioner Signature: _____

Appointment cancellation, late or missed appointments and general policies.

Please read and sign below.

Any appointment that is not canceled with at least a 48 hour notice will incur a charge for the full amount of the appointment with the credit card on file. There will be no option to reschedule to avoid being charged. Scheduling another appointment will be for the full amount of that additional appointment. Obvious exclusions apply (if the client is involved in an accident or otherwise struck ill).

Any missed appointment or 'no-show' will incur a charge for the full amount of the appointment with the credit card on file. There will be no option to reschedule to avoid being charged. Scheduling another appointment will be for the full amount of that additional appointment.

Any client who shows up late to their appointment will be charged for the full amount of the appointment and will receive treatment until the original scheduled end time. They will not receive extra time for their treatment.

Myofascial Wisdom reserves the right to dismiss patients for inappropriate conduct, non or late payment of appointments, medical reasons, safety concerns and other reasons as determined by the therapist.

All forms of payment are welcome including credit/debit cards *but,* when you can, please use checks, cash, Venmo or Zelle to avoid high cost credit card processing fees incurred on Myofascial Wisdom PLLC. Payment for an appointment is required at the time of your visit. Returned checks will incur a $25.00 fee, due and payable immediately. Any product purchased must be paid in full at time of service and is non refundable.

Insurance is not accepted and it is the sole responsibility of the patient to receive reimbursement from their carrier. Any invoices requested will be provided after payment is received.

I have reviewed, understood and agree to abide with the office policies as stated above.

Sign_____ Date_____