Joe Miller, LCMT—Myofascial Release Therapy Intake Information

The information you supply on this form will enable your therapist to give you treatment that is proper and appropriate, based on your health concerns and condition. This information will be kept confidential between you and your therapist. This information will not be shared with any party without your written consent.

Please answer all questions completely. Use additional paper if necessary.

Name _____

Address _____

_____

City _____

State _____ Zip _____

Phone Best: _____

Alternate: _____

Email _____

Male ☐ Female ☐ Non-cis ☐
Prefer not to answer ☐ Birth date _____

Occupation _____

Daily activities _____

_____

_____

Please indicate those you have had:

Myofascial Release ☐ CranioSacral Therapy ☐

Massage ☐ Other _____

Primary complaint: _____

How did this develop? _____

What makes it worse? _____

Interferes with: Work ☐ Sleep ☐ Recreation ☐ (describe) _____

What makes it better? _____

Have you seen a physician about this? Yes ☐ No ☐ Name _____

If so, what did the physician say? _____

Medications you take and purpose: _____

Major accidents, surgeries, illnesses:
(describe and indicate date of each) _____

_____

Are you pregnant and, if so, due when? Yes ☐ No ☐ Due date _____

In the following conditions, please indicate any that you have:

☐ abdominal hernia	☐ blood pressure, high	☐ eczema	☐ hands, numbness	☐ sciatica
☐ allergies	☐ bursitis	☐ edema	☐ headaches	☐ shingles
☐ arthritis	☐ cancer	☐ ears, ringing	☐ heart condition	☐ shoulder pain
☐ back pain, low	☐ chest pain	☐ fainting	☐ hepatitis	☐ sinusitis
☐ back pain, general	☐ constipation	☐ fatigue	☐ HIV/AIDS	☐ skin disorders
☐ balance, loss of	☐ depression, severe	☐ feet, cold	☐ neck pain	☐ TMJ dysfunction
☐ blood clots	☐ diabetes	☐ feet, numbness	☐ PMS	☐ varicose veins
☐ blood pressure, low	☐ dizziness	☐ hands, cold	☐ psoriasis	☐ warts

☐ other (describe) _____

_____

I understand that my therapist must be aware of all my known medical conditions and physical limitations. I have listed all my known medical conditions and physical limitations here and will inform my therapist of any changes in my physical health.

I agree that all services rendered to me are charged directly to me and that I am responsible for payment at the time services are rendered unless other arrangements are made **prior to treatment.** I agree to pay an appointment cancellation fee equal to the charge for the scheduled services for any cancelled appointment, unless I notify Joe Miller, LCMT, at least 24 hours in advance.

I give my permission for the treatment that I am given and understand that it is no substitute for medical care.

Client signature _____ Date _____