# Intuit Myofascial Release

## Client Intake Form

Please answer the following questions as accurately as possible. The information provides will be helpful in creating treatment sessions that meet your specific needs.

### PERSONAL INFORMATION:

Name:_____ Date:_____
Address:_____
Date of Birth:_____ Telephone-Cell:_____ E-Mail:_____
Occupation:_____
Who Referred you for treatment_____

### MEDICAL INFORMATION:

Primary Physician or Chiropractor: _____
Phone Number_____

What is the PRIMARY compliant that brings you in for treatment today?
_____
_____
_____

Any secondary complaints you would like to address?
_____
_____

Please describe any pain, limited range of motion or difficulty with activities due to your symptoms:_____
_____
_____
_____

How and when did these issues begin?
_____
_____
_____
_____

Please list history of trauma, accidents or surgery:
_____
_____
_____

What are your goals for therapy?
_____
_____
_____
_____

## Please circle any of the conditions you've had in the past or currently have:

Cardiovascular Disease Diabetes (Type 1 or 2) Congestive Heart Failure
Neurological Condition Pregnancy Headaches/Migraines Sinus Problems
Osteoporosis Blood Clots Arthritis Multiple Sclerosis Tension/stress
Depression Chronic Fatigue Syndrome/Fibromyalgia
Numbness/Tingling Back or Neck Pain Anxiety HIV/AIDS Rash/Skin
Conditions High Blood Pressure Chronic Infections Tendonitis TMJ/Jaw Pain
Chest Pain/Tightness Constipation/Diarrhea Epilepsy/Seizures Varicose Veins
Kidney Disease Earaches/Ringing in Ears Menstrual Issues
Digestive Problems Thyroid Conditon Muscle/Joint Pain

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE INFORMATION IS COMPLETE AND TRUE. IF MY MEDICAL/HEALTH STATUS SHOULD CHANGE, I WILL NOTIFY MY THERAPIST IMMEDIATELY.

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 I should see a physician or other qualified medical specialist for any mental or physical ailment that is beyond the scope of practice of my Occupational Therapist. Because Myofascial Release 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 UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING FOR ANY APPOINTMENT CANCELLATION OF LESS THAN 24 HOURS _____(initials)

Client Signature:_____Date:_____

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Individual Treatment Rates: $110/hour session, $160/1.5 hour session

*To help you commit to your healing, treatment packages are offered at a discounted rate. We have found that treatment is much more effective when clients attend 3 times a week or twice a week. Therefore, packages are tailored for clients maximum progress.*

## Treatment Package Options:

6- 60 Minute Myofascial Release sessions- $625 ($35 savings)
6- 90 Minute Myofascial Release sessions- $925($35 savings)

10- 60 Minute Myofascial Release sessions- $1,000($100 savings)
10-90 Minute Myofascial Release Sessions-$1,500 ($100 savings)

Please note that treatments may only be applied only to **your** future treatments and may not be shared with anyone else except a spouse or child. Sessions remain on your account until they are used or for one year, whichever comes first. Thank you for your trust in this powerful modality!