Medical History Intake Form

Patient Name_____Date _____

I am seeking Myofascial Release Therapy to help with (check all that apply):

Reducing Pain Levels_____ Increasing Movement/Mobility_____ Improving Posture Dysfunction_____

Post-Surgical Scar Adhesions_____ Pelvic Pain & Dysfunction_____ Improving Function & Performance_____

General Wellness & Self-Care_____ Other_____

My primary complaint or area of most pain is: _____
_____

My pain is: constant_____ intermittent (comes & goes) _____ sporadic_____fluctuates depending on activity

or time of day_____ worse in the morning_____ worse at night_____ Other_____

Usual pain level from 0 to 10: (none) 0 1 2 3 4 5 6 7 8 9 10 (extreme)

Pain levels: best_____ worst_____

How long have you been experiencing these symptoms and/or pain? (please use exact or approximate dates):
_____
_____

Did your pain come on suddenly or gradually? _____ Due to_____
_____

Since onset, is your pain: better_____ worse_____ not changing _____

Describe your pain/symptoms: (check all that apply) sharp_____ burning_____ shooting_____ tightness_____

achy_____ pressure_____ cramping_____ spasms_____ tingling_____ numbness_____ nausea_____

What activities aggravate it? (check all that apply) walking short distances_____ walking long distances_____

driving____ standing____ sitting____ running____ carrying/lifting____ bending____ reaching_____ squatting_____

housekeeping_____ recreational activities____ sexual intercourse_____ bowel/bladder activity____ Other_____

What gives you relief? heat ____ ice ____ hot shower/bath ____ stretching ____ resting_____ lying down _____

anti-inflammatories/pain medication _____ nothing decreases my pain _____ other _____

Have you recently, or in the past, been seen or treated by another Health Care Practitioner (i.e. doctor, specialist, therapist) for your stated condition/complaint? Yes_____ No_____

If so, please list whom you've seen and when: _____
_____
_____

What forms of traditional and/or alternative treatments have you tried in the attempts of treating your pain?
_____
_____
_____

Please indicate any additional areas of pain, limitations, or concerns you feel you therapist should know:
_____
_____

In addition to the above information, do you have a history or experience any problems with:

digestion_____ acid reflux/GERD____ constipation/regular bowel movements_____ frequent urination or urgency____

urinary incontinence_____ difficulty emptying bladder completely_____ gas/bloating____ painful intercourse_____

menstrual or ovulation pain_____ headaches/migraines_____ difficulty sleeping_____

List ALL medical conditions, past and present: (ie. diabetes, cancer, hypertension, etc.)
_____
_____
_____
_____

List ALL over-the-counter and/or prescription medications you are currently taking:
_____
_____
_____

List ALL major and minor surgeries you have had. Please note to include cosmetic procedures & surgeries as well: (ie. tummy tuck, breast augmentation, etc.)
_____
_____
_____
_____

List any falls, car accidents, head injuries or traumas (major and minor) you can recall:
_____
_____
_____

What are your stress levels normally? high_____ low_____ moderate/average_____

On a scale from 0 to 10, 0 being no stress & 10 being extreme stress what is your current stress level? _____

Are you currently under high stress levels and/or have you recently experienced a major life stressor? (ie. death in the family, divorce, marital separation, loss of work, etc.) Yes _____ No_____ Explain _____
_____

Please note anything else you feel your therapist should know in order to maximize your care and treatment:
_____
_____

What are your Goals for therapy? (i.e. decrease pain, increase mobility, improve posture, etc.)

My Primary Goals include: _____
_____
_____

My Secondary or Long-term Goals include: _____
_____
_____

**In the best interest and well-being of the patient, it is the patient's responsibility to inform and keep the therapist up to date with any and all changes regarding medical status, medications, medical testing & procedures and all doctor visits that are related to their care.

Patient Name (print) _____ Date_____

Patient Signature _____

Therapist Signature & Date _____