MUSCLE MECHANICS THERAPY – CLIENT INFORMATION FORM

Name ________________________________

Address ________________________________

City ________________ Zip ______________

Referred by ____________________________

Phone ________________________________

E-Mail ________________________________

Facebook/Instagram______________________

Date of Birth _______________ Age _________

Occupation or Student:

____

Employer or School:

____

Sports/Position (if applicable):

____
____
____

History of Symptoms:
Reason(s) for treatment in order of discomfort:
1) ____________________________________
2) ____________________________________
3) ____________________________________
4) ____________________________________

When did you first notice primary complaint?

____

Is this condition getting progressively worse?
Yes _____ No _____

What have you done to get relief?

____
____

Has there ever been a medical diagnosis?

Yes _____ No ____

If yes, what was it? _________________________

Who made the diagnosis? ____________________

Have you ever had:

	No	Yes	Describe
Surgery			
Broken bones			
Injured muscles			

Accidents (falls, auto, bike, sports, etc.):

Date: ____________________________________

Date: ____________________________________

Date: ____________________________________

Family history of blood clots?
No ____ Yes ____

Blood Type: O____ A____ B____ AB____

Have you been diagnosed as auto immune (e.g., lupus, celiac, MS, fibromyalgia, etc.)?
No ______ Yes ______

Are you pregnant or trying to become pregnant?
No ______ Yes ______

When you wake in the morning do you feel better or worse than when you went to bed?
Better______ Worse _____ Same ______

Sleep Position by Percentage? (%)
Back ________
Right side ________
Left side ________
Stomach ________

Circle the appropriate answers:

- At your desk/workstation is your computer screen situated **at** or **below** eye level?
- Is it situated directly **in front** of you, to your **left** or **right**?
- Is your keyboard **on your desktop** or on an **under the desk tray**?
- Is your mouse **on your desktop** or on an **under the desk tray**?
- Are you **right** or **left** handed?

How many hours a day are you seated?
Include time at work/school, in your car, watching television, eating, etc. _____hours

How much of these do you consume daily?
Water ________________________________
Coffee/Tea/Milk/Dairy__________________
Soda/Juice/Sports Drinks________________
Alcohol_______________________________
Tobacco/Nicotine _____________________

Are you currently taking any medication?

Yes _______ No ________ If yes, list them:
____
____

Do you use Orthotics (shoe inserts)? Yes______ No_______

Emergency Contact Person:

Name________________________________

Phone________________________________

Please read the following statements sign and/or initial below.

P & M Myofascial Release is a combination of Myofascial Release, Trigger Point Therapy and Deep Tissue Massage, among other things, with movement through assorted ranges of motion that helps lengthen the muscle, (and the fascial sheath that covers it), to realign your body structurally.

I understand that this technique is often painful and is the primary technique used at Muscle Mechanics Therapy. ______ (Initial)

I give my consent for the therapists at Muscle Mechanics Therapy to use their best judgment to work on the areas of my body necessary to effect the changes we together, are working towards.
______ (Initial)

I understand that the therapists will cover clients with sheets and/or towels to provide comfort and modesty. Male and female genital areas will remain covered at all times. Please communicate with the therapist if you are uncomfortable with the draping procedure.
______ (Initial)

I understand that "breast massage" will only be used as a modality at Muscle Mechanics Therapy if prescribed by the client's physician and is deemed medically necessary and is accompanied by the written consent of the client. _____ (Initial)

I understand that the client or I have the right to end any massage session at any point during the massage for any reason. _____ (Initial)

I understand that massage therapy is not a substitute for medical examination and diagnosis. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder.
______ (Initial)

I understand that I must give 24 hours' notice of canceling any appointment to avoid being billed for the scheduled appointment. _____ (Initial)

___________________________/_____________
Sign **Date**

I am 18 years of age or older ________ (initial)

If Client is under the age of 18 please fill out the Treatment Release Form for Minors

Please fill this section out completely. Goals should include activities that you cannot do now that you want to resume when you are well.

What are your expectations for this visit/ short – long term goals?

____

____

____

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____

____

List areas of pain/dysfunction in order of importance to you and mark those areas in on the pictures provided:

1) ___________________________________

2) ___________________________________

3) ___________________________________

4) ___________________________________

5) ___________________________________

Please use the following marks:

XX	**Sharp pain**
//	**Dull pain**
++	**Numbness/Tingling**
##	**Achy pain**
OO	**Throbbing pain**

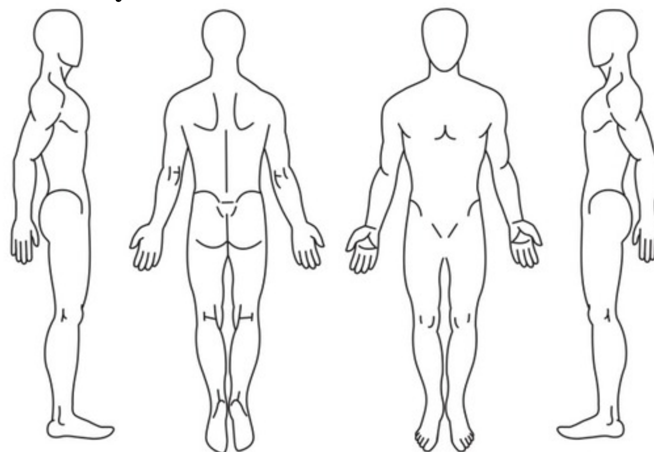
Are the symptoms constant or intermittent?

____

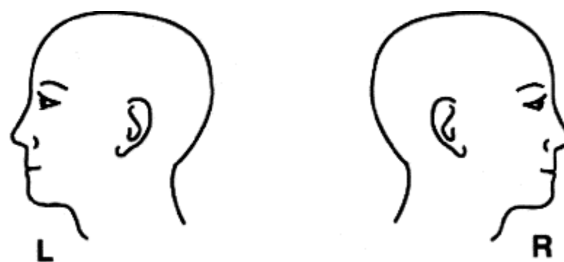
________________________/_____________

Sign **Date**

Full Body:

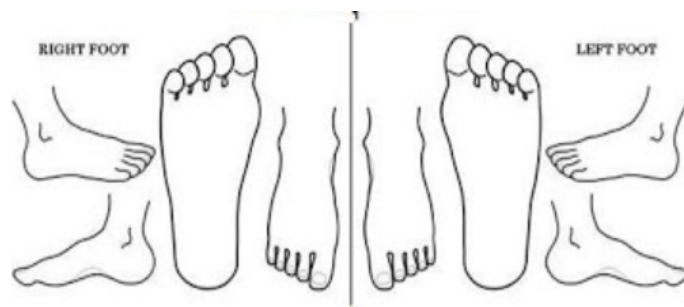


Head and neck:



Hands:

Feet:



Therapist's Notes

Date: ______________________________

Notes:____

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Date: ______________________________

Notes:____

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Date: ______________________________

Notes:____

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