

MYOFASICAL HEALING

DANA DEGRAW, LMBT

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 _____