VELOCITY
Sports Medicine & Rehabilitation

Fascial Stretch Therapy Patient Intake Form

Name: _____ Date: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Birth Date (MM/DD/YR): _____Occupation: _____

Emergency Contact: _____ Referred By: _____

Phone – Home: _____ Phone – Work: _____

Phone - Mobile: _____ E-Mail: _____

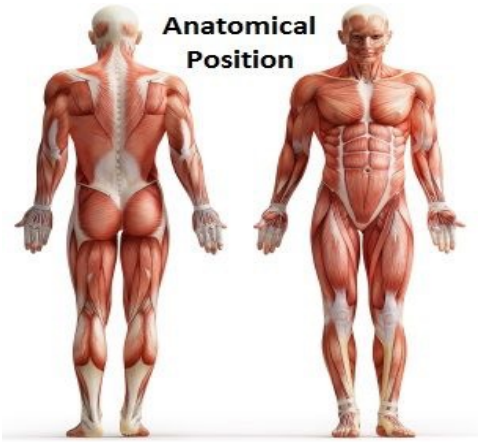
General Information:

What is your main reason for coming to therapy? _____

What specific goals would you like to achieve from therapy? _____

How and when did the symptoms begin? _____

Where are your symptoms located? Please mark the areas on the figures below:



How long have you had these symptoms? _____

Are you currently, or have you ever been, under medical supervision for this problem?_____

Have you had any tests for this problem; such as x-rays, MRI or CT scans? _____

Describe the symptoms. Please check all that apply:

□ Dull □ Ache □ Burning □ Sharp □ Periodic □ Constant □ Sore □ Stiff □ Numb □ Tingling

What makes it better or worse? _____

On a scale of 0 to 10 with 10 being the most severe imaginable discomfort, what is your discomfort level now? _____

What time of day is the pain worse? _____

Do you have trouble sleeping? If yes, what position do you sleep in? _____

Physical Factors:

What physical activities are you currently involved in? _____

Do you stretch now? _____ Do you feel flexibility is an important part of fitness? _____

Have you ever had chiropractic treatment? If yes, how long, how often and with whom? _____

Have you ever seen a Naturopathic doctor? _____

Have you experienced any kind of bodywork before (i.e. massage, acupuncture, etc.)? If yes, what type? _____

Do you wear any type of supportive braces anywhere? _____ Do you wear orthotics? _____ If yes, how long? _____

What percentage of your day is spent sitting? _____, standing? _____, driving? _____

Are your symptoms worse at the end of the workday? _____

Does your work station give you support and encourage good posture? _____

How would you rate your own posture? _____

Medical History

Please list any recent injuries, illnesses, or surgeries: _____

Are you currently under the care of a physician? Yes_____ No_____ If yes, please explain. _____

_____

List current medications, including aspirin, ibuprofen, etc. _____

Please check all that apply

- Cancer Type: ____
- Digestion Problems ____
- TMJ _____
- Migraines/Headaches
- Back Problems ____
- Sciatica ____
- Stroke ____
- Scoliosis ____
- Osteoporosis ____
- Diabetes ____
- Hi/Low Blood Pressure ____
- Elimination Problems ____
- Respiratory Problems ____
- Immune Disorder ____
- Now Pregnant ____
- Sinus Problems ____
- Epilepsy ____
- Ulcers ____
- Cold Hands/Feet ____
- Heart Problems ____
- Bruise Easily ____
- Allergies ____
- Fibromyalgia ____
- Carpal Tunnel ____
- Asthma ____
- Immovable Joints ____
- Neck Problems ____
- Arthritis/Bursitis ____
- Tendonitis ____

Have you had any accidents, auto or other? _____

Have you ever had any major surgeries? _____
Have you ever had a head injury? _____ Have you noticed dizziness? _____ Change in hearing? _____
Change in vision?_____

Are there any other medical conditions the therapist should be aware of? _____

Are you pregnant? _____ If yes, how far along are you? _____

The above information is accurate and true to the best of my knowledge. If there are any changes in my current level of health, I will inform the person here that I'm seeing of my condition. I understand that this office does not diagnose or treat illness or disease and does not prescribe medications. I agree to pay my account with this office in accordance with the regular rates and payment terms. If, for any reason cancellation is necessary, I will give a 24-hour notice. I understand that if I do not give this notice, I will be charged for the appointment unless it can be filled. Emergency cancellations will be determined by owner. It is agreed that any claim of liability is hereby waived.

Patient Signature: _____ Date: _____