Sun Star Healing & Myofascial Release, LLC
Client Intake Information

Name:_____ **DOB:**_____ **Age:**_____

Address:_____

_____

Phone # (Home/Cell):_____**Email:**_____

Emergency Contact (Name/Phone #):_____

What gender do you identify as?_____ **Marital Status:**_____

Occupation:_____ **Currently Working:**_____ **F/T P/T**

Referred By:_____

Reason for seeking Myofascial Release treatment:_____

_____

_____

How long have you been experiencing this condition?_____

Does your condition affect your sleep? Yes/No If yes, please explain:_____

_____

_____

What daily activities does your condition prevent you from doing or inhibit your performance?

_____

_____

Pain or Discomfort Level (circle one)

Scale: 0 1 2 3 4 5 6 7 8 9 10
(least) (worst)

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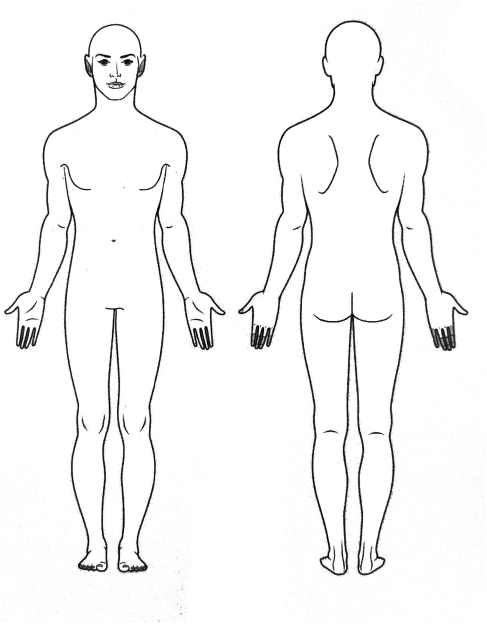
Shade in the areas of pain, discomfort or symptoms:



Personal Goals: (What do you want to accomplish by the end of your treatment?)_____

_____

_____

Are you sensitive to touch or pressure?_____

Please check ☑️ if you have experienced or currently have any of the conditions listed:

___Allergies
___Excessive coughing/congestion
___Asthma/shortness of breath
___Sore/achy/stiff muscles
___Tendonitis/torn ligaments
___Skin rashes/eruptions
___Cardiovascular Disease
___Digestive problems
___ Arthritis
___Neurological Disorder
___Cancer
___Aneurysm
___Autoimmune Disease
___Reproductive problems
___Headaches
___Clenching/grinding teeth(TMJ)
___Eye strain
___Numbness/tingling
___Musculoskeletal Disorder
___High Blood Pressure
___Lung Disease
___Kidney Disease
___Scoliosis
___Seizure Disorder
___Benign Tumors
___Immune Deficiency
___Bowel/Bladder problems
___Spinal/Back problems
___Extreme fatigue
___Earache/ringing
___Blurred vision
___Diarrhea
___Constipation
___Vertigo
___Diabetes
___Osteoporosis
___Fibromyalgia
___Stroke
___Blood Clots
___Infectious Disease
___Pregnancy(#:____)
___Fractured bones

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___Sadness	**___Excessive worry/fears**	**___Anxiety**
___Depression	**___Feelings of inadequacy**	**___Suicidal thoughts**
___Abuse (physical, verbal emotional, sexual)	**___Addictions:_____**	**___Substance Abuse: _____**
___Other:	**___PTSD (Post Traumatic Stress Disorder)**	

Physical/Emotional/Mental Traumas (Include accidents, injuries, abuses, attacks etc, and indicate whether sustained as a child or adult):_____

_____

_____

_____

Surgical Procedures:_____

_____

_____

_____

Implants of *any kind* (stent, pacemaker, internal defibrillator, insulin pump, mesh, joint replacement, breast augmentation etc.):_____

_____

Medications/Supplements/Herbal Remedies (list reason for taking):_____

_____

_____

_____

Are you pregnant or is there a possibility that you are pregnant?_____

Signature:_____ Date:_____

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Informed Consent

I understand that Myofascial Release is a hands-on and manual form of treatment including close visual assessment, palpable examination, and possible photographs for postural comparison and education during evaluation and re-evaluation. I also understand that during treatment sessions, I will be wearing limited clothing in order to comprehensively treat the fascial system of the body.

I understand that it is important to provide accurate health information for safe and effective treatment. I have completed and submitted my client intake form to my occupational therapist, Margot M. Jones. If there are any updates, it is my responsibility to inform her.

I understand in order to get the best possible results for my health and well-being, it is necessary to receive multiple sessions consecutively. Following my initial evaluation, my occupational therapist will discuss with me the recommendations and plan of care.

I understand the Myofascial Release treatment does not negate the need for medical or psychological examination, diagnosis and treatment, and that I should seek such attention if my condition goes beyond the scope of practice of my occupational therapist. I also understand that treatment and possible risks of treatment will be discussed with me and that there is no absolute guarantee of the outcome of treatment. I have the right to refuse treatment at any time and will notify my occupational therapist in writing.

I understand that my personal health information is kept private and confidential, and will only be disclosed as required by law.

I understand that payment is expected in full at the end of each session.

I understand that if I need to cancel, 24 hours notice has to be given prior to my scheduled appointment.

I understand that any inappropriate or harassing remarks or behaviors by me will be terms for immediate termination of treatment, and I will be responsible for the full payment of the session.

I consent to Myofascial Release treatment by Margot M. Jones, OTR/L and release her from any claims or liabilities associated with receiving treatment.

_____ _____

Print Name Signature

_____ _____

Signature of Parent/Guardian Date