Welcome to our practice!

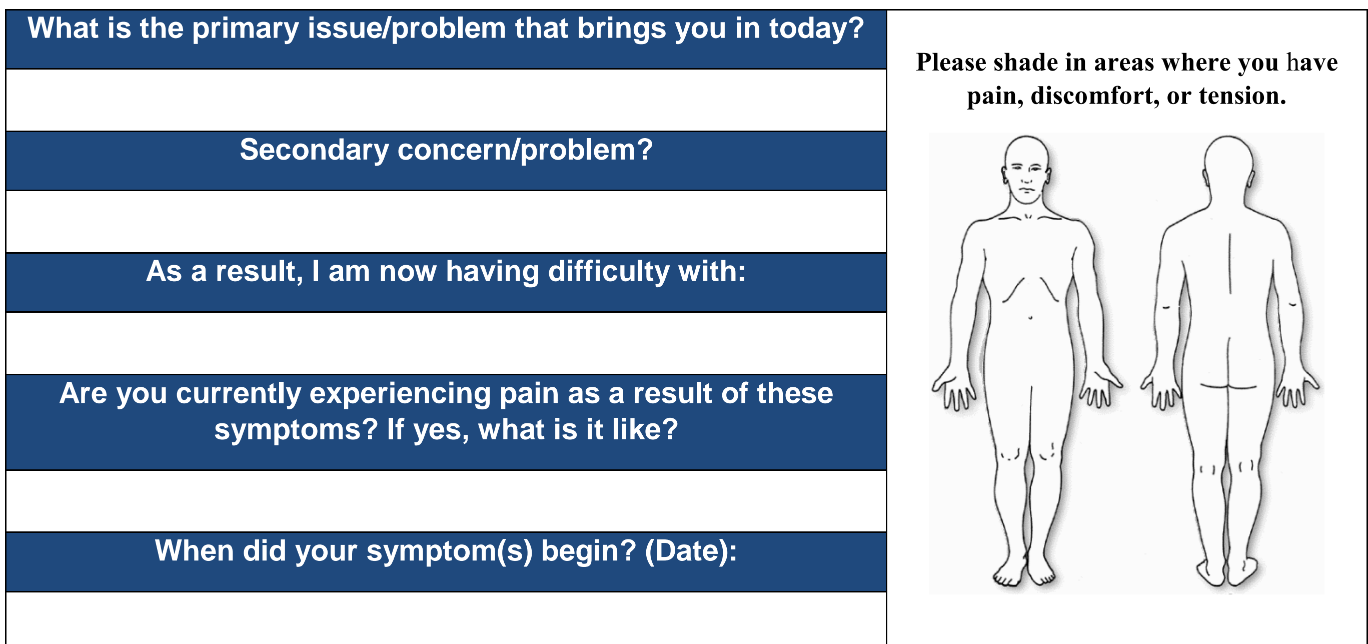
Please help us serve you better by taking a few minutes to provide the following information.

Name:			Today's date:				
	Last Name	First Name					
Address:							
City / State / ZIP:							
Phone #	MOBILE		HOME		WORK		
DOB:		Age:		Marital status:	M	S	W	D
Email:							
Occupation:		Employer:					
Emergency Contact	Name:		Phone:				

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

The following is very important in our evaluation process.

Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.



What is the primary issue/problem that brings you in today?	Please shade in areas where you have pain, discomfort, or tension.
Secondary concern/problem?	
As a result, I am now having difficulty with:	
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?	
When did your symptom(s) begin? (Date):	

Check the box if you have had any of the following medical conditions?											
	Diabetes		Lung disease		Weight change		Varicose veins		Neurological problems		Pregnancy
	Rheumatic fever		Osteoporosis		Migraine headaches		Epilepsy / seizures		Stroke		Blackouts
	Heart Murmur		Malignancy		Arthritis		Broken bones (fracture		Metal implants		High blood pressure
	Circulatory problems		Liver disease		Heart disease / pacemaker		Kidney disease		**Others (explain below)**		

List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).

Medication	For treatment of	Dose / Amount per day	Effectiveness

Informed Consent

I understand that Blue Ridge Myofascial Release, LLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

Photographs taken during initial evaluation, progress evaluation and discharge summary will be used for postural comparison purposes and as educational tools. By signing below I consent to the use of these photographs in a professional manner.

I do hereby agree and give my consent for Blue Ridge Myofascial Release, LLC to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I hereby certify that all the above information is true to the best of my knowledge.

Patient/Parent/Guardian Signature:__________________

Date:__________________