HEALTH HISTORY & NEW PATIENT INTAKE FORM

Bold fields are required.

Date		***Emergency contact***	
Name (First, Last, MI)		***Phone #***	
Address		PCP or referring Physician	
City/State/Zip		*Address*	
Age / Date of Birth		*Suite Number*	
Sex		*City/State/Zip*	
Home phone		*Phone number*	
Work phone		*Fax Number*	
Mobile phone		I give my manual therapist permission to consult with my referring health care provider regarding my health and	Signature
e-Mail			

Current Health Information

Please list concerns and check all that apply

What is your Primary Complaint? ______

☐ mild ☐ moderate ☐ severe

☐ constant ☐ intermittent

☐ symtoms ⇧ w/activity ☐ symptoms ⇩ w/activity

☐ getting worse ☐ getting better ☐ no change

Treatment received ______

What is your Secondary Concern? ______

☐ mild ☐ moderate ☐ severe

☐ constant ☐ intermittent

☐ symtoms ⇧ w/activity ☐ symptoms ⇩ w/activity

☐ getting worse ☐ getting better ☐ no change

Treatment received ______

Any Additional Complaints? ______

☐ mild ☐ moderate ☐ severe

☐ constant ☐ intermittent

☐ symtoms ⇧ w/activity ☐ symptoms ⇩ w/activity

☐ getting worse ☐ getting better ☐ no change

Treatment received ______

Have you ever received Manual Therapy before?

☐ Y ☐ N Frequency? ______

Are you receiving treatment for other conditions?

☐ Y ☐ N If yes, what are they? ______

Daily activities

Describe how your condition functionally limits the following activities.

Work ______

Home/Family ______

Recreational ______

Check other activities affected: ☐ sleep ☐ washing ☐ dressing ☐ fitness

How do you reduce stress? ______

In general, do you prefer to sit or stand? ______

If you're in acute pain, what is your most comfortable position? ______

Health History (continued on back)

Are you taking any medications? ______

List and explain. Include dates and treatment received.

Surgery ______

Accidents ______

Major Illnesses ______

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General

Current	Past	Comments
☐	☐	Headaches ______
☐	☐	pain ______
☐	☐	sleep disturbances
☐	☐	fatigue ______
☐	☐	infections ______
☐	☐	fever ______
☐	☐	sinus ______
☐	☐	other ______

Skin Conditions

Current	Past	Comments
☐	☐	rashes ______
☐	☐	athlete's foot ______
☐	☐	other ______

Allergies

Current	Past	Comments
☐	☐	scents, oils, lotions
☐	☐	detergents ______
☐	☐	other ______

Muscles and Joints

Current	Past	Comments
☐	☐	rheumatoid arthritis ______
☐	☐	osteoarthritis ______
☐	☐	osteoporosis ______
☐	☐	scoliosis ______
☐	☐	broken bones ______
☐	☐	spinal problems ______
☐	☐	disc problems ______
☐	☐	lupus ______
☐	☐	TMJ, jaw pain ______
☐	☐	spasms, cramps ______
☐	☐	sprains, strains ______
☐	☐	tendonitis, bursitis ______
☐	☐	*stiff or painful joints*
☐	☐	weak or sore muscles ______
☐	☐	neck, shoulder, arm pain ______
☐	☐	low back, hip, leg pain ______
☐	☐	other ______

Nervous System

Current	Past	Comments
☐	☐	head injuries ______
☐	☐	concussions ______
☐	☐	dizziness ______
☐	☐	ringing in ears
☐	☐	loss of memory
☐	☐	confusion
☐	☐	numbness ______
☐	☐	tingling ______
☐	☐	sciatica ______
☐	☐	*shooting pain* ______
☐	☐	chronic pain ______
☐	☐	depression ______
☐	☐	other ______

Respiratory & Cardiovascular

Current	Past	Comments
☐	☐	heart disease ______
☐	☐	blood clots ______
☐	☐	stroke ______
☐	☐	lymphedema ______
☐	☐	high/low blood pressure
☐	☐	irregular heart beat ______
☐	☐	poor circulation ______
☐	☐	swollen ankles ______
☐	☐	varicose veins ______
☐	☐	chest pain ______
☐	☐	*shortness of breath*
☐	☐	asthma ______
☐	☐	COPD ______

Cancer/Tumors

Current	Past	Comments
☐	☐	Benign ______
☐	☐	Malignant ______

Digestive/Elimination system

Current	Past	Comments
☐	☐	bowel dysfunction ______
☐	☐	gas, bloating ______
☐	☐	bladder/kidney dysfunction ______
☐	☐	abdominal pain ______
☐	☐	other ______

Endocrine System

Current	Past	Comments
☐	☐	*thyroid dysfunction* ______
☐	☐	diabetes ______

Reproductive System

Current	Past	Comments
☐	☐	pregnancy ______
☐	☐	painful menses ______
☐	☐	fibrotic cysts ______

Habits

Current	Past	List Frequency
☐	☐	tobacco ______
☐	☐	alcohol ______
☐	☐	drugs ______
☐	☐	coffee ______
☐	☐	ergogenic aides ______

Movement & Exercise

Current	*Past*	*List Frequency*
☐	☐	Stretching/Yoga ______
☐	☐	Cardiorespiratory ______
☐	☐	Strength/Resistance ______
☐	☐	balance/speed/agility ______

Contract for Care & Consent for Care

Contract for Care. I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my *manual therapist* and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my *manual therapist* any time I feel my well being is threatened or compromised. I expect my *manual therapist* to provide safe and effective treatment.

Consent for Care. It is my choice to receive *bodywork/manual therapy*, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my *manual therapist* of any changes in my health.

Signature/Date ______________________ Signature/Date of parent or *guardian if patient is a minor.* ______________________

INFORMED CONSENT and PATIENT AGREEMENT

I, the undersigned, hereby authorize James Holzer, LMT, to perform
manual therapy and specific procedures necessary for Fascial Counterstrain (FCS) treatment.

What is Fascial Counterstrain (FCS)?

Fascial Counterstrain is a technique that uses gentle manual manipulations to help restore function to the fascial systems of the body (arterial, visceral, lymphatic, venous, dural, periosteal, and nervous systems). Benefits of FCS include stress reduction, circulation enhancement, increased relaxation, and relief from muscular tension, soreness, and pain.

Limitations of FCS:

FCS practitioners do not diagnose medical diseases or conditions and it is not a substitute for medical examination and treatment.

Self-care after treatment:

• Following a session, please make sure to consume an adequate amount of pure water.

• Try to avoid heavy lifting or heavy physical activity for the week following a session.

NOTE: Please understand that despite the gentle nature of the fascial counterstrain technique, there is a very real possibility that you will get sore following a session. Sometimes in extreme cases you may feel worse. In most cases this is evidence of a powerful change in your body, not another injury. Usually, this is temporary and should not last more than 2-3 days. There is no way to predict how one will respond to fascial counterstrain treatment, but you can minimize the reaction by following the guidelines listed above.

Adverse Reactions to FCS:

Please provide complete details of medical conditions and medications to your treatment provider during the health-intake interview. Failure to inform the manual therapist of all medical conditions and medications may place you at increased risk for adverse reactions. If you experience any discomfort during the session, immediately inform your practitioner so he or she can adjust your treatment. Sometimes treatment is followed by temporary soreness, fatigue or discomfort related to tissue toxicity and the early stages of detoxification.

Informed Consent: With this knowledge, I voluntarily consent to the above procedures, realizing that James Holzer, LMT, has given no guarantees to me regarding
cure or improvement of my condition. I hereby release James Holzer, LMT, from any and all liability, which may occur in connection with the above-mentioned procedures except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that FCS requires practitioners to gently touch and manipulate my body, possibly including breast tissue and the pelvic floor. I understand that FCS is not a method to diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of FCS. I understand that FCS is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have and I have

stated all my known physical conditions and medications. I also understand the benefits and limits of FCS therapy and understand it may cause adverse reactions in certain rare situations. I release my practitioner of any liability if I fail to disclose the appropriate health-related information. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself, or unless required by law. I understand that my practitioner will answer any questions I have.

Client's Signature: ______________________________ Date: _______________

I authorize James Holzer, LMT, to provide treatment to my child or dependent.

Name of Child or Dependent: ____

Parent or Guardian Signature: _________________________ Date: ___________

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