New Life Myofascial Release, LLC.

CONTACT DETAILS

NAME:	**NAME OF REPRESENTATIVE IF UNDER 18:**
ADDRESS:	**TELEPHONE:**
DATE OF BIRTH:	**EMAIL:**

NAME OF EMERGENCY CONTACT:	**RELATIONSHIP:**
TELEPHONE:	**ALT TELEPHONE:**

NAME OF EMERGENCY CONTACT:	**RELATIONSHIP:**
TELEPHONE:	**ALT TELEPHONE:**

New Life Myofascial Release, LLC.

INFORMED CONSENT

PATIENT NAME: _____

_____I do hereby consent to receive treatment from Jennifer L. Glass OTR/L for occupational therapy and myofascial release. I am fully aware of the potential side effects and risks of treatment and I understand that I can request that treatment be stopped at any time, and no further treatment will be provided. I agree to assume any risks posed with this treatment and freely consent to treatment.

_____I consent to and understand that during my evaluation, re-evaluation and treatment that articles of clothing may be removed for assessment and manual handling. I also understand that and consent to the fact that an assessment of my body will take place and that a visual review and observation of my body may occur.

_____I understand that it is my responsibility to inform my occupational therapist of my complete medical history and status including medications . I have a completed medical history form which is complete and may be amended at any time if additional medical conditions are discovered or diagnosed.

_____I agree that there have been no guarantees for results or outcomes related to my treatment.

_____I hereby agree to release Jennifer L. Glass, OTR/L and New Life Myofascial Release, LLC from any claims or liabilities associated with receiving this treatment.

_____I have completely read and understood the above consent form and hereby agree to receive treatment from Jennifer L. Glass OTR/L. I understand that consent may be withdrawn at any time and treatment will cease immediately.

_____ _____

Client Signature **Date**

New Life MFR

New Life Myofascial Release, LLC.
MEDICAL HISTORY AND STATUS

CLIENT NAME: _____ **DOB:** _____

Please list any current medical conditions which you have experienced, you are receiving treatment for or have had treatment in the past:

Please list any surgeries you have received or are upcoming (attach additional sheets if necessary):

Do you have any of the following:

Condition	Yes/No	Condition	Yes/No
Pacemaker		Cancer	
Diabetes		Hernia	
Stroke		Mental Health Tx	
Pregnancy		Blood Clots	
Seizures		Skin Conditions	

New Life Myofascial Release, LLC.

Please list all medications including natural remedies or supplements:

Medication	Dosage	Frequency	Reason for Taking

Please list any other information regarding your medical status or care that you feel is relevant:

_____

_____

Please explain the reason you have sought treatment today: _____

_____

When did your symptoms begin? _____

Please list any accidents or traumas that may have caused or exacerbated your pain or injuries:

_____

_____

_____

New Life Myofascial Release, LLC.

Do you experience pain in any of these areas?

___Low Back ___Upper Back ___Neck ___Head

___Shoulders ___Hips ___Knees ___Feet

Please list any other areas where you experience pain or discomfort:

_____

_____

Pain level at best:
1 2 3 4 5 6 7 8 9 10

Pain level at worst:
1 2 3 4 5 6 7 8 9 10

What relieves the pain?

___Rest ___Ice ___Heat ___Over the Counter Medication

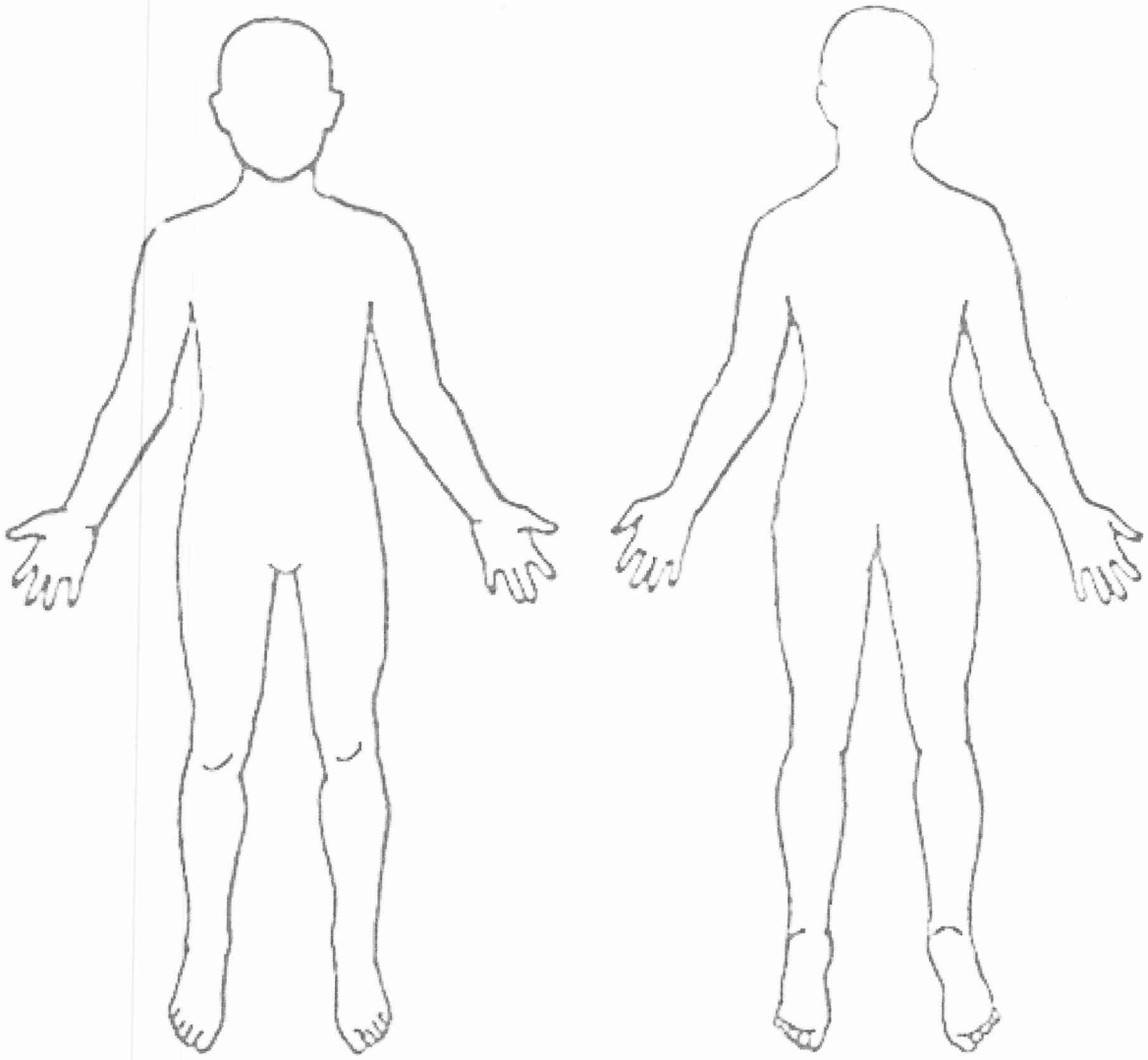
___Prescription Medication ___Movement ___Nothing

___Other: _____

What other types of treatments have you had in the past for your pain?

___Physical/Occupational Therapy ____Massage ___Chiropractor

___Acupuncture ___Reiki or other energy work ___Other: _____



Please mark any areas of Pain, Discomfort or Tightness