Southern Maryland
Myofascial Release

Physical Therapy/Myofascial Release/CranioSacral Therapy/Trigger Point Dry Needling
90 Holiday Drive, Suites C&D1, PO Box 273, Solomons, MD 20688
Phone: 410-449-6682 Fax: 410-449-6684
www.jouneyingintohealing.com

Patient Intake Form

First Name: _____ Middle Initial: _____
Last Name: _____ Date of Birth: _____ / _____ / _____ Age: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____
Occupation: _____ Are you currently working? Yes / No # of Hours: _____
Emergency Contact: _____ Phone: _____
Relationship to Patient: _____
Referring Physician: _____ Phone: _____ N/A: _____
Name of Health Insurance Company: _____
(Note: We are able to see individuals with Medicare/Medicaid insurance as long as you pay out of your own pocket, as we are not an enrolled provider - please ask if you have any questions regarding this policy.)
Whom may we thank for this referral: _____
Preferred method of contact (please circle): home phone / cell phone / text msg. / email / other: _____
Would you like to receive emails including office forms, service updates, etc.? (please circle) Yes / No

Past Medical History:
Please circle Yes or No for each. Give explanation for each Yes in the space provided below.

Yes/No High Blood Pressure	Yes/No Implants
Yes/No Heart Attack	Yes/No Joint Swelling/Pain
Yes/No Stroke	Yes/No Diabetes
Yes/No Angina/Chest Pain	Yes/No Changes in Vision
Yes/No Pacemaker	Yes/No General Fatigue
Yes/No Other Cardiac Issues	Yes/No Depression
Yes/No Seizures/Epilepsy	Yes/No Shortness of Breath
Yes/No Cancer	Yes/No Allergies
Yes/No Osteoporosis	Yes/No Problems with Bowel
Yes/No Arthritis	Yes/No Problems with Bladder
Yes/No Surgery	Yes/No Vertigo/Dizziness
Yes/No Fractures	Yes/No Skin Sensitivities/Rashes
Yes/No Headaches	Yes/No Ringing in the ears
Yes/No Pregnancy	Yes/No Blackouts
Yes/No Weight Changes (>15lbs.)	Yes/No Recent Hospital Admission-dates: _____
Yes/No HIV/AIDS	Yes/No Other:_____

Notes:_____
_____
_____
_____

I am: RIGHT / LEFT hand dominant **I consider my current health status to be:** Good / Fair / Poor

Please list any other traumas, accidents or other conditions (including dates) that you have had throughout your life.
_____
_____
_____

Medications:
Please list any medications (including over the counter and supplements) that you are currently taking.

_____
_____
_____
_____

Have you ever received any of the following treatment for your current condition?

■Physical Therapy	Yes / No	How Long? _____	Helpful?	Yes / No
■Chiropractor	Yes / No	How Long? _____	Helpful?	Yes / No
■ Acupuncture	Yes / No	How Long? _____	Helpful?	Yes / No
■ Myofascial Release	Yes / No	How Long? _____	Helpful?	Yes / No

Are you currently under the care of a physician for this condition? Yes / No

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 FUNCTIONAL ABILITY AND SYMPTOMS.

1) What is your primary complaint that brings you to us? Please describe your symptoms as specifically as possible.

_____
_____
_____
_____

2) On or about what date did your symptoms begin? _____

3) How did your symptoms begin? For example, did your symptoms begin as a result of an accident or trauma, or did they begin without a known reason?

_____
_____
_____

4) If a motor vehicle accident (please circle appropriate answers): You were the *driver / passenger* in a *car / truck / SUV* that *hit / was hit* by a *car / truck / SUV*.

5) Please rate your pain on a scale from 0-10 (0=no pain, 10=emergency room pain)
On my best day, at my best time: _____
On my average day, at an average time: _____
On my worst day, at my worst time: _____

6) Please put a slash mark on the line below to rate the frequency of your symptoms:

No pain---------- Constant Pain

7) Has your pain had an impact on your emotional and or spiritual well-being? Yes / No

8) On the lines below, please put a slash mark to indicate your functional ability as a % of normal.

On a good day: 0%----------100%

On a bad day: 0%----------100%

9) The following section if from the Oswestry Disability Index and will help us better understand how your pain affects your ability to manage everyday life activities. Please check the box for ***the one statement*** in each section that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that ***most closely*** describes your present-day situation.

Pain Intensity
- ☐ 0 My pain is mild to moderate. I do not need pain killers.
- ☐ 1 The pain is bad, but I manage without taking pain killers.
- ☐ 2 Pain killers give complete relief from pain
- ☐ 3 Pain killers give moderate relief from pain
- ☐ 4 Pain killers give very little relief from pain
- ☐ 5 Pain killers have no effect on the pain

Personal Care (Dressing, bathing, etc.)
- ☐ 0 I can look after myself normally without causing extra pain
- ☐ 1 I can look after myself normally, but it causes extra pain
- ☐ 2 It is painful to look after myself; I am slow and careful
- ☐ 3 I need some help but manage most of my personal care
- ☐ 4 I need help every day in most aspects of my self-care
- ☐ 5 I do not get dressed; I wash with difficulty and stay in bed

Lifting
- ☐ 0 I can lift heavy weights without extra pain
- ☐ 1 I can lift heavy weights, but it gives me extra pain
- ☐ 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table.
- ☐ 3 Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ 4 I can lift only very light weights.
- ☐ 5 I cannot lift or carry anything at all.

Walking
- ☐ 0 I can walk as far as I wish
- ☐ 1 Pain prevents me from walking more than 1 mile.
- ☐ 2 Pain prevents me from walking more than ½ mile.
- ☐ 3 Pain prevents me from walking more than ¼ mile.
- ☐ 4 I can walk only if I use a cane or crutches.
- ☐ 5 I am in bed or in a chair for most of every day.

Sitting
- ☐ 0 I can sit in any chair for as long as I like.
- ☐ 1 I can sit in my favorite chair only, but for as long as I like.
- ☐ 2 Pain prevents me from sitting for more than 1 hour.
- ☐ 3 Pain prevents me from sitting for more than ½ hour.
- ☐ 4 Pain prevents me from sitting more than 10 minutes.
- ☐ 5 Pain prevents me from sitting at all.

Standing
- ☐ 0 I can stand as long as I want without extra pain.
- ☐ 1 I can stand as long as I want, but it gives me extra pain.
- ☐ 2 Pain prevents me from standing for more than 1 hour.
- ☐ 3 Pain prevents me from standing more than ½ hour.
- ☐ 4 Pain prevents me from standing more than 10 minutes.
- ☐ 5 Pain prevents me from standing at all.

Sleeping
- ☐ 0 Pain does not prevent me from sleeping well.
- ☐ 1 I sleep well but only when I taking medication.
- ☐ 2 Even when I take medication, I sleep less than 6 hours.
- ☐ 3 Even when I take medication, I sleep less than 4 hours.
- ☐ 4 Even when I take medication, I sleep less than 2 hours.
- ☐ 5 Pain prevents me from sleeping well at all.

Social Life
- ☐ 0 Social life is normal and causes me no extra pain.
- ☐ 1 Social life is normal, but increases the degree of pain.
- ☐ 2 Pain affects my social life by limiting only more energetic interests, such as dancing, sports, etc.
- ☐ 3 Pain has restricted my social life, and I do not go out as often.
- ☐ 4 Pain has restricted my social life to my home.
- ☐ 5 I have no social life because of pain.

Changing Degree of Pain
- ☐ 0 My pain is rapidly getting better.
- ☐ 1 My pain fluctuates, but overall is definitely getting better.
- ☐ 2 My pain seems to be getting better, but improvement is slow at present.
- ☐ 3 My pain is neither getting better nor worse.
- ☐ 4 My pain is gradually worsening.

Traveling
- ☐ 0 I can travel anywhere without extra pain.
- ☐ 1 I can travel anywhere, but it gives me extra pain.
- ☐ 2 Pain is bad, but I manage journeys over 2 hours.
- ☐ 3 Pain restricts me to journeys of less than1 hour.
- ☐ 4 Pain restricts me to necessary journeys under ½ hour.
- ☐ 5 Pain prevents traveling except to the doctor/hospital.

Total Score: _____ /50

PLEASE CONTINUE TO NEXT PAGE

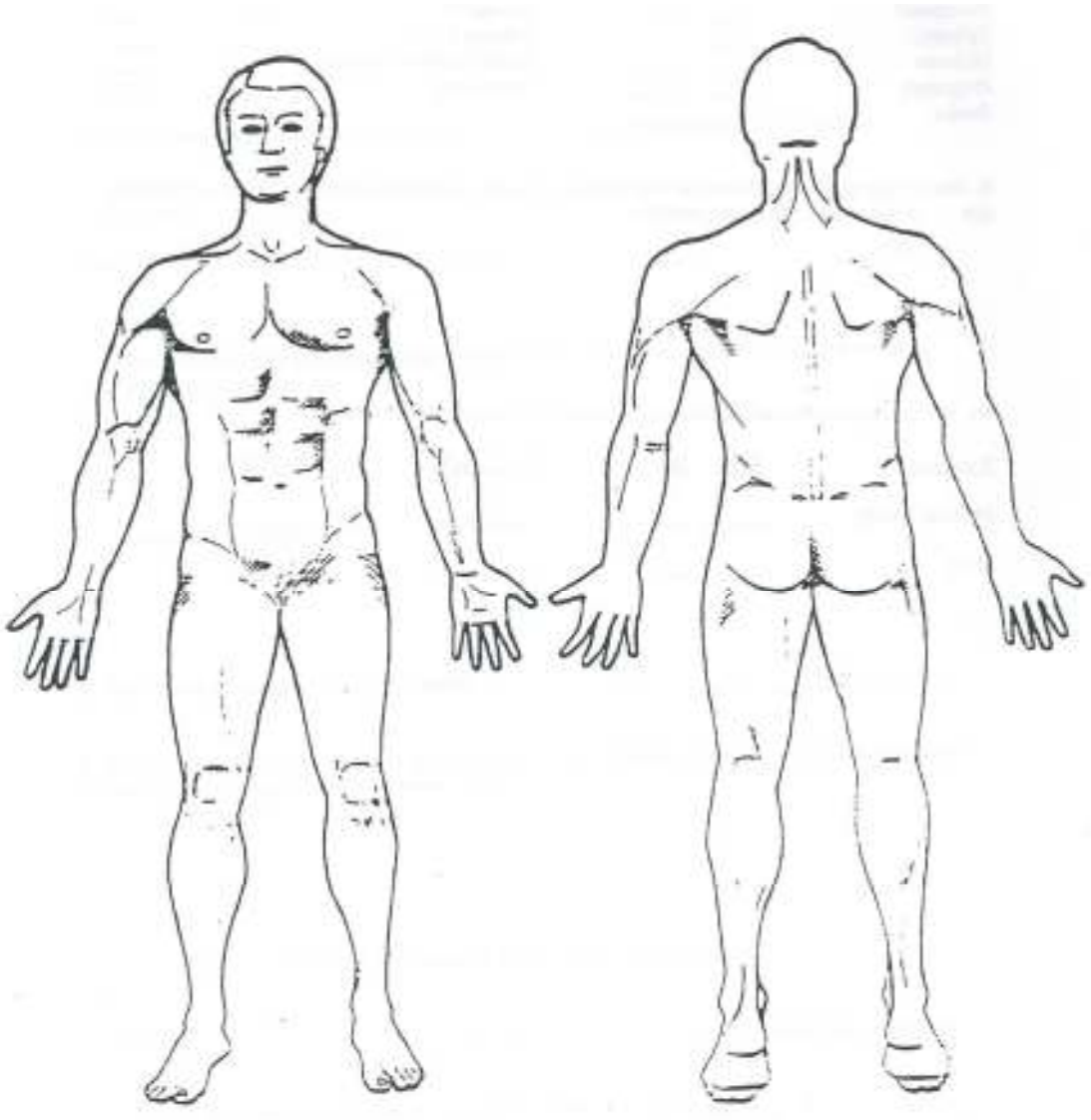
10) What are your **goals** for physical therapy? For example, what activities from the above list would you like to perform better or longer? How long in minutes or hours do you want to or need to perform each activity? Please be specific and share at least three.

_____
_____
_____
_____

11) Please list for us any diagnostic tests you have had performed (i.e. X-ray, MRI, etc.) and any associated findings.

_____
_____
_____
_____

Please shade areas of pain on the diagram below.



Once shaded, you may also choose to write a “T” over areas that feel tight, “W” for areas that feel weak, and “N” for areas where you feel numbness or tingling.

Please place a "√" in front of each item that you experience at least monthly. Place an "X" in front of each item that you experience weekly or more frequently.

_____ Headaches
_____ Heart Pounding or Racing
_____ Irregular Heart Beat
_____ Chest Pain/Tightness
_____ Numbness/Tingling in Arm or Leg
_____ Cannot Keep Warm Enough
_____ Sweaty Palms
_____ Blushing/Flush Face
_____ Coughing
_____ Stuffy Nose/Congestion
_____ Earache or Ringing in Ears
_____ Common Colds
_____ Sore Throat
_____ Asthma or Shortness of Breath
_____ Hay Fever or Allergies
_____ Sore/Aching Muscles
_____ Stiff or Tender Joints
_____ Back Problems
_____ Trembling/Twitching Muscles
_____ Skin Rashes/Eruptions
_____ Grinding of Teeth (TMJ)
_____ Dry Mouth
_____ Mouth Sores
_____ Excessive Perspiration
_____ Difficulty Falling Asleep
_____ Difficulty Sleeping Through Night
_____ Awaken Too Early In Morning
_____ Excessive Drowsiness during Day
_____ Periods of Extreme Fatigue
_____ Feeling Faint or Dizzy
_____ Feeling Tense or Nervous
_____ Difficulties with Family/Friends
_____ Worrisome Thoughts
_____ Recurring Bad Thoughts
_____ Thoughts of Suicide
_____ Fearful of Persons/Places

_____ Feeling Inadequate/Unable to Cope
_____ Feeling of Guilt/Failure
_____ Uncontrolled Sadness or Crying
_____ Easily Annoyed/Irritated
_____ Free Floating Anxiety about Life
_____ Voice Quivering, Shaking
_____ Eyes Irritated or Inflamed
_____ Vision Blurred
_____ Eyestrain or Discomfort
_____ Nosebleeds
_____ Stomach Cramps
_____ Heartburn/Indigestion
_____ Nausea or Vomiting
_____ Frequent Urination
_____ Incomplete Urination
_____ Painful Urination
_____ Urinary Leakage
_____ Bowel Leakage
_____ Gas in Lower Bowel
_____ Diarrhea
_____ Constipation
_____ Bowel Irregularity
_____ Uninterested in Sex Relations
_____ Unable to Enjoy Sexual Activity
_____ Unable to Participate in Sex Acts
_____ Menstrual Difficulties
_____ Pre-Menstrual Syndrome
_____ Breast Tenderness
_____ Hot Flashes
_____ Water Retention
_____ Over-Eating/Bingeing
_____ Lack of Appetite
_____ Excessive Alcohol Abuse
_____ Other Substance Abuse
_____ Frequent Laxative Use
_____ Other:

Please Continue to Next Page

Medical History Affirmation

I, _____, affirm that I have stated all known prior and current medical conditions and medications as stated in the above sections. I have answered all questions honestly and clearly to the best of my knowledge. I agree to keep Southern Maryland Myofascial Release updated as to any changes in my medical profile as they may pertain to my plan of care. I also understand that there shall be no liability on the therapist's part should any information I have provided be false or inaccurate or should I fail to notify the therapist of any change in my medical condition or profile while under care.

Fee Schedule

Evaluation: $250 (Evaluation and treatment)

(The evaluation fee is charged for the initial session for any patient new to the clinic or the initial session for any patient returning for care under a new diagnosis)

Follow-Up Visits: $125 per 1 hour session, $190 per 1½ hour session

Consent for Treatment

I hereby consent to treatment as deemed to be medically necessary and appropriate by Southern Maryland Myofascial Release Inc. I acknowledge that the therapist has discussed such treatment with me including any and all risks associated with the treatment. All fees associated with my care have been disclosed to me at this time. I understand that I will be charged **IN FULL** for any appointments that I cancel or miss without 24 hours prior notice. This cancellation fee will be due and payable before scheduling a new appointment or completing any other scheduled appointments. I also understand that if I arrive late to a scheduled appointment I will receive the remainder of my booked time but will be liable for payment in full. All fees are due at time of service and will be paid in full in the form of cash, check or credit card. A fee of $25.00 will be charged for any returned checks. All sessions are by appointment only.

Patient Signature **Date**

_____ _____

Consent for the treatment of a minor

By my signature below I hereby authorize physical therapy treatment to my child or dependent as deemed medically necessary and appropriate.

Parent/Guardian Signature **Date**

_____ _____

Privacy Notice: Your information and records will only be used for purposes of providing care and will not be shared with any outside party without prior written consent.

Southern Maryland
Myofascial Release

Physical Therapy/Myofascial Release/CranioSacral Therapy/Trigger Point Dry Needling
90 Holiday Drive, Suites C&D1, PO Box 273, Solomons, MD 20688
Phone: 410-449-6682 Fax: 410-449-6684
www.jouneyingintohealing.com

Patient Privacy Practices

This notice describes how medical information collected by Southern Maryland Myofascial Release may be used and disclosed. It is also intended to tell you how you can access this medical information. Please take the time to review this document thoroughly before signing it. Thank you.

Treatment

The health information we collect from you during your sessions at Southern Maryland Myofascial Release may be used by staff members and disclosed to other health care professionals on staff for the purpose of evaluating your condition and providing appropriate care. Any staff member who may provide treatment or be consulted regarding your treatment will have access to your medical records.

Business Operations

Your medical information may be used to help support the management and operations of day to day business at Southern Maryland Myofascial Release. This includes use for statistical and financial reporting as well as assisting in quality of care management and business practices.

Uses That Require Your Authorization

If your health information is to be used for any purpose other than the ones stated above, Southern Maryland Myofascial Release requires your written authorization to do so. Please request a **HIPPA Authorization and Consent for Release of Documentation** form should this be necessary. You can revoke this authorization in writing should you change your mind, however, your decision to do so will not undue any disclosure of information that occurred prior to receiving your notification.

Patient Rights

Under Federal privacy standards, you have certain rights which include the following:

- The right to receive a printed copy of this notice.
- The right to receive a listing of all individuals to whom which your protected information has been disclosed, and by what means it was disclosed.
- The right to inspect and copy your protected health information.
- The right to amend and/or submit corrections to your protected health information.
- The right to request restrictions on the disclosure and use of your protected health information.
- The right to receive confidential communication regarding your medical condition and treatment.

By law, we are required to maintain the privacy of your protected health information and to give you a copy of this notice. We are also required to abide by the policies and practices that have been outlined above. We reserve the right, as permitted by law, to revise out privacy practices and policies at any time. These changes may also be due in part to a change in Federal or State laws and regulations. Should our privacy policies and practices need to be revised, you will be provided with a copy of the new policy upon the next visit to our office.

Requests to Review Your Protected Health Information

As allowed by Federal regulation, any request for inspection of, or copy of, your protected health record must be made in writing. At that time we will provide you with our **HIPPA Authorization and Consent for Release of Documentation** form. Please take note that the law allows the charge of a clerical fee ($10) plus $0.25 per page copy fee for any copies of your medical record. You may also be charged for the subsequent expense of mailing or faxing your documents to the appropriate party. Any concerns regarding this policy can be submitted to Southern Maryland Myofascial Release Inc.

By My Signature Below

I hereby verify that I have read the above patient privacy policy and acknowledge my rights as a client of Southern Maryland Myofascial Release Inc.

_____

Signature of Client or Representative **Today's Date**