

# Adirondack Myofascial Release

62 Beekman Street Saratoga Springs, NY 12866

Date \_\_\_\_\_ Name: \_\_\_\_\_

How do you prefer to be addressed? \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Occupation \_\_\_\_\_ Are you currently working? \_\_\_\_\_ Hours per week \_\_\_\_\_

What problem brings you here today? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

The following is very important to the 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.

- Below you will find a list of common activities that patients have difficulty performing because of their symptoms. For each activity, please note the time in minutes or hours that you can perform it before you feel the need to stop because of your symptoms. If you have no difficulty with the activity, write "OK". If you are unable to perform the activity, write "Unable".

Activity	Tolerance	Activity	Tolerance
Sitting	_____	Computer Work	_____
Standing	_____	Exercise	_____
Walking	_____	Writing	_____
Stairs # of stairs/flights)	_____	Shopping	_____
Driving	_____	Bending	_____
Sleeping	_____	Reaching (# of repetitions)	_____
Household chores vacuuming	_____	Lifting (# of pounds)	_____
Cooking	_____	Carrying (# of pounds)	_____
Laundry	_____	Other _____	_____
Dish Washing	_____	_____	_____

- What are your goals for 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 or need to perform each activity?

3. On the line below, place a slash mark to indicate your functional ability as a % of normal

On a good day 0% \_\_\_\_\_ 100%

On a bad day 0% \_\_\_\_\_ 100%

4. What is your primary complaint that brings you for therapy? Please describe your symptoms as specifically as possible.

5. When (what date) did your symptoms begin?

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

7. Put a slash mark on the line below to rate the INTENSITY of your symptoms:

No pain \_\_\_\_\_ worst pain imaginable

8. Put a slash mark on the line below to indicate the FREQUENCY of your symptoms:

No pain \_\_\_\_\_ constant pain

9. Do you have any of the following medical conditions?

	Yes	No		Yes	No
Circulatory problems	_____	_____	Black outs	_____	_____
High blood pressure	_____	_____	Visual Disturbances	_____	_____
Heart trouble	_____	_____	Weight changes (> 15 lbs.)	_____	_____
Pace maker	_____	_____	Headaches	_____	_____
Epilepsy	_____	_____	Ringling in ears	_____	_____
Pregnancy	_____	_____	Bowel/Bladder problems	_____	_____
Stroke	_____	_____	Malignancy	_____	_____
Diabetes	_____	_____			

10. Are you on any medications? Please list

11. Past medical History: Please list any surgeries, accidents, traumas or other conditions that you have had along with the approximate dates for each.

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

	Yes	No	How long?	Helpful?
Physical Therapy	___	___	_____	_____
MFR	___	___	_____	_____

NOTICE OF ADVICE: As of November 2006 New York State allows direct access to Physical Therapy without a referral from a doctor, dentist or nurse practitioner for up to 30 days or 10 visits, whichever comes first. This notice is to advise you that your health insurance company may not cover PT without a referral, while they may cover PT with a referral.

Please sign and date below that you have read and understand this advice. Thank you.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

