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.

1. 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	_____	_____	_____

2. 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 a n 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	____	____	Ringing 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:_____