



Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell#: _____ Work#: _____

E-mail address: _____

Occupation: _____

Briefly describe condition(s) motivating you to seek Myofascial Release treatment: _____

When and how did this condition develop? _____

What makes it better? _____

What makes it worse? _____

Please describe your therapeutic goal(s): _____

Please check (and explain if necessary) any conditions that apply to you.

- inflammation _____
- joint pain _____
- osteoporosis _____
- scoliosis _____
- arthritis (specify type) _____
- tendonitis _____
- skin conditions _____
- current cellulitis _____
- current fever _____
- carpal tunnel syndrome _____
- plantar fasciitis _____
- circulatory problems _____
- swelling/edema _____
- pregnancy (check if remotely possible) _____
- blood clots (past or present) _____
- high/low blood pressure _____
- heart condition _____

- pacemaker/defibrillator _____
- aneurism _____
- stroke history _____
- neurological conditions _____
- headaches _____
- vertigo _____
- jaw popping/clicking _____
- TMJ dysfunction _____
- bruxism _____
- depression _____
- anxiety _____
- insomnia _____
- fibromyalgia _____
- chronic fatigue syndrome _____
- general fatigue _____
- cancer (past or present) _____
- diabetes (type) _____

turn page----->



Accidents/Injuries: _____

Surgeries (including dental): _____

Current medications: _____

Daily water consumption: less than one 1 quart 1-2 quarts 2 quarts or more

Do you feel you have a balanced diet? Yes No

Do you exercise frequently? Yes No If yes, specify how and frequency: _____

Treatment fee: The first session costs \$150 and is at least 90 minutes in length. Subsequent sessions are either 60 minutes /\$100 or 90 minutes/\$150. Payment is expected at the end of each session, unless other arrangements have been made. Cash and check are the preferred methods of payment, although credit and debit cards can be processed.

Cancellation Policy: Your appointment time is reserved exclusively for you. Kindly provide 24 hours notice in the event that you need to cancel your appointment. You will be expected to pay the *full session fee* for sessions missed for reasons other than illness or circumstances beyond your control.

Consent for treatment: Myofascial Release is a whole body treatment, as fascia penetrates and creates the immediate environment of every cell in the body. Depending on my symptoms, therapeutic goals, and/or where Owen discovers myofascial restrictions in my body, appropriate treatment may include techniques applied directly to buttocks. Remarkably, state law requires Owen to obtain consent for such procedures.

I give my consent for direct treatment to buttock area. yes no

I have listed all my known medical conditions and physical limitations. I will inform Owen of any changes to my physical health. I am responsible for consulting a qualified physician for any physical and/or psychological ailments that I may have. I understand that Owen's work should not be used as a substitute for this care. Owen does not diagnose any physical or psychological disorders, nor does he prescribe medications or perform spinal manipulations.

I understand the above statements and release Owen Dodge from any and all claims of malpractice, nondisclosure, or lack of informed consent. I freely assume any and all risks of treatment whether presently contemplated or hereinafter discovered.

Signature _____

Date _____

Please mark an "X" over areas of discomfort.

