TRIANGLE BODY THERAPY

PLEASE ANSWER THE FOLLOWING BEFORE YOUR FIRST VISIT WITH OWEN:

NAME:

_____

FIRST LAST

DATE OF BIRTH: _____I_____I_____

M D Y

EMAIL ADDRESS: _____

PREFERRED PHONE: _____ _____ _____**MOBILE** ☐ **HOME** ☐ **WORK** ☐

MAILING ADDRESS: _____

STREET

_____ _____ _____

CITY STATE ZIPCODE

OCCUPATION:_____

HOW DID YOU HEAR ABOUT TRIANGLE BODY THERAPY?

☐ **FRIEND/FAMILY** ☐ **PROFESSIONAL REFERRAL** ☐ **WEBSITE**

☐ **MFR DIRECTORY** ☐ **OTHER:**_____

IF REFERRAL, IS THERE SOMEONE OWEN CAN THANK?

_____

PRIMARY CONCERN OR PROBLEM MOTIVATING YOU TO SEEK TREATMENT:

_____

_____

_____

THIS PROBLEM CAUSES DIFFICULTY WITH:

_____

APPROXIMATELY WHEN DID THIS PROBLEM BEGIN?

_____

IF YOUR PRIMARY PROBLEM IS PAINFUL, PLEASE RATE YOUR PAIN ON A SCALE OF 1-10, WITH 10 BEING WORST:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

WHAT OTHER TYPES OF TREATMENT HAVE YOU TRIED TO TREAT THIS ISSUE?

☐ MEDICAL DOCTOR ☐ SURGERY ☐ PT/OT ☐ CHIROPRACTIC

☐ MASSAGE/BODYWORK ☐ ACUPUNCTURE ☐ OTHER

SECONDARY PROBLEMS OR ISSUES?

_____

_____

CAUSE DIFFICULTY WITH:

_____

_____

APPROXIMATELY WHEN DID THESE PROBLEMS BEGIN?

_____

IF YOUR SECONDARY PROBLEMS ARE PAINFUL, PLEASE RATE YOUR PAIN ON A SCALE OF 1-10,WITH 10 BEING WORST:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

WHAT OTHER TYPES OF TREATMENT HAVE YOU TRIED TO TREAT THIS ISSUE?

☐ MEDICAL DOCTOR ☐ SURGERY ☐ PT/OT ☐ CHIROPRACTIC

☐ MASSAGE/BODYWORK ☐ ACUPUNCTURE ☐ OTHER_____

PLEASE LIST THE OUTCOMES YOU WANT AS A RESULT OF TREATMENT:

_____

OTHER THERAPEUTIC GOALS: _____

_____

CHECK ANY WHICH CURRENTLY PERTAIN TO YOU:

- ☐ OSTEOPOROSIS
- ☐ SCOLIOSIS
- ☐ ARTHRITIS
- ☐ DEGENERATIVE DISC(S)
- ☐ BONE SPUR(S)
- ☐ SPINAL STENOSIS
- ☐ SOFT TISSUE TEAR
- ☐ TENDONITIS
- ☐ BURSITIS
- ☐ BROKEN/FRACTURED BONE
- ☐ ARTIFICIAL JOINT(S)
- ☐ METAL HARDWARE
- ☐ FREQUENT HEADACHES
- ☐ TMJ PROBLEMS
- ☐ VERTIGO
- ☐ PREGNANCY (CHECK IF REMOTELY POSSIBLE)
- ☐ BLOOD CLOT
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ ANEURISM
- ☐ PACEMAKER
- ☐ DEFIBRILLATOR
- ☐ DIABETES
- ☐ CANCER (PAST OR PRESENT)
- ☐ COMMUNICABLE DISEASE
- ☐ CURRENT FEVER

OTHER CONDITIONS YOU THINK OWEN SHOULD KNOW ABOUT:

_____

PLEASE LIST YOUR HISTORY OF SIGNIFICANT ACCIDENTS, INJURIES AND/OR SURGERIES (INCLUDING EYE AND/OR DENTAL SURGERIES) AND APPROXIMATE DATES.

_____

_____

_____

_____

PLEASE LIST ANY MEDICATIONS TAKEN TO CONTROL PAIN OR TO THIN YOUR BLOOD: _____

OTHER MEDS? (OPTIONAL)

_____

ARE YOU PSYCHOLOGICALLY STABLE? **YES** ☐ **NO** ☐

DO YOU EXERCISE REGULARLY? **YES** ☐ **NO** ☐

IF YES, WHAT TYPE AND HOW OFTEN?

_____

_____

ARE YOU CURRENTLY TRAINING FOR AN EVENT? **YES** ☐ **NO** ☐

ARE YOU ABLE TO EXERCISE NOW? **YES** ☐ **YES, BUT WITH MODIFICATIONS** ☐

NO ☐

DO YOU WEAR: **CUSTOM ORTHOTICS** ☐ **HEEL LIFT** ☐

CONTACT LENSES ☐ **HEARING AID(S)** ☐

WIG / TOUPEE / HAIR WEAVE ☐

IS THERE ANYTHING ELSE YOU THINK OWEN SHOULD KNOW?

_____

_____

_____

CONSENT FOR TREATMENT:

I GIVE OWEN DODGE PERMISSION TO PROVIDE THERAPEUTIC TREATMENT THAT WILL INCLUDE “HANDS-ON” MANUAL THERAPY AND MAY ALSO INCLUDE INSTRUCTIONS FOR MY OWN THERAPEUTIC EXERCISE. I UNDERSTAND THAT I AM AN ACTIVE PARTICIPANT IN MY OWN HEALING, AND IT IS MY RESPONSIBILITY TO PROVIDE OWEN WITH ACCURATE AND TIMELY FEEDBACK REGARDING MY RESPONSE TO TREATMENT IF I EXPERIENCE PAIN OR DISCOMFORT DURING THE SESSION. I WILL IMMEDIATELY INFORM OWEN SO THE TECHNIQUES CAN BE ADJUSTED TO MY LEVEL OF COMFORT AS NECESSARY.

I MAY BECOME AWARE OF MEMORIES AND/OR EMOTIONS AS A RESULT OF TREATMENT, AND I AM FREE TO EXPRESS THEM AS PART OF MY HEALING PROCESS. I MAY EXPERIENCE PAIN AND/OR SORENESS AFTER MY TREATMENT. I UNDERSTAND THAT THIS IS PART OF MY HEALING PROCESS. I CAN CHOOSE TO STOP THE TREATMENT COMPLETELY FOR ANY REASON AT ANY TIME.

I AFFIRM THAT I HAVE INFORMED OWEN OF ALL MY KNOWN MEDICAL CONDITIONS AND WILL KEEP HIM UPDATED AS TO CHANGES IN MY MEDICAL CONDITION. OWEN DOES NOT DIAGNOSE ANY PHYSICAL OR PSYCHOLOGICAL SYMPTOMS, AND NOTHING SAID OR DONE BY HIM SHOULD BE MISCONSTRUED AS SUCH. OWEN DOES NOT PRESCRIBE MEDICATION OR PERFORM HIGH VELOCITY SPINAL MANIPULATIONS. 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 A SUBSTITUTE FOR THIS CARE.

☐ CHECK HERE IF YOU UNDERSTAND AND AGREE.

CANCELLATION POLICY:

YOUR APPOINTMENT TIME IS RESERVED EXCLUSIVELY FOR YOU. PLEASE PROVIDE AT LEAST 24 HOURS NOTICE IN THE EVENT YOU NEED TO RESCHEDULE OR CANCEL YOUR APPOINTMENT. **IF YOU ARE SICK OR HAVE HAD A FEVER IN THE PAST 24 HOURS**, **PLEASE RESCHEDULE**. YOU WILL BE CHARGED 1/2 THE SESSION FEE FOR SESSIONS MISSED FOR OTHER REASONS. THIS POLICY ALSO PERTAINS TO EMERGENCY CANCELLATIONS AT OWEN'S DISCRETION.

☐ CHECK HERE IF YOU UNDERSTAND AND AGREE.

CONSENT FOR TREATMENT IN THE ERA OF COVID-19:

I UNDERSTAND THAT, BECAUSE MYOFASCIAL RELEASE INVOLVES MAINTAINED TOUCH AND CLOSE PHYSICAL PROXIMITY OVER AN EXTENDED PERIOD OF TIME, THERE MAY BE AN ELEVATED RISK OF DISEASE TRANSMISSION DURING THE THERAPY SESSIONS, INCLUDING COVID-19. FURTHERMORE, A CAUSAL CONNECTION HAS BEEN ESTABLISHED BETWEEN COVID-19 AND THE DEVELOPMENT OF BLOOD CLOTS. MANUAL THERAPY SUCH AS MYOFASCIAL RELEASE COULD DISLODGE BLOOD CLOTS INTO YOUR BLOOD STREAM WITH POSSIBLY FATAL CONSEQUENCES. I ACKNOWLEDGE THAT I AM AWARE OF THESE RISKS INVOLVED FROM RECEIVING TREATMENT. I VOLUNTARILY AGREE

TO ASSUME THOSE RISKS, AND I RELEASE AND HOLD HARMLESS OWEN DODGE AND TRIANGLE BODY THERAPY FROM ANY CLAIMS RELATED THERETO. I GIVE MY CONSENT TO RECEIVE TREATMENT FROM OWEN DODGE.

☐ CHECK HERE IF YOU UNDERSTAND AND AGREE.

CLIENT SIGNATURE: _____

PARENT OR GUARDIAN SIGNATURE (IN CASE OF A MINOR):

_____

DATE: _____