Sacramento Myofascial Release

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Dear Client,

Thank you for your interest in my physical therapy/myofascial release services. I look forward to working with you.

An hour (or hour-and-a-half) has been set aside for you. Please give the consideration of 24 hours advance notice if you are unable to keep the appointment. Otherwise, you will be expected to pay the (hour) visit fee of $100. Preferred payment method is with cash or check. Cards are accepted via Square.

Some suggestions to help you enjoy your visit more fully:
-wear loose-fitting shorts or a bathing suit bottom. Women should also wear a bathing suit top, bra, and/or tank top. You will be able to change your clothes at the clinic.
-remove all jewelry.
-do not apply any lotion to your body as this will greatly reduce the effectiveness of the treatment.
-eat lightly or not at all before treatment.

After your treatment, drink 6-8 glasses of water spaced throughout the rest of the day. This will help to flush out toxins from your body. If possible, allow yourself quiet time afterwards.

Please fill out the included patient questionnaire before coming (and bring it with you). Feel free to call if you have any further questions.

Sincerely,

Jocelyn Littlejohn, PT

Today's Date _____

Client Information Form

Name: _____

Address: _____

City, State, Zip: _____

Phone number(s): _____

E-mail: _____

Physician: _____

Phone #: _____

Person to contact in emergency: _____

Phone #: _____

Relationship to you: _____

How did you hear of my services? _____

_____

Primary Complaint/Diagnosis:_____

_____

Date of Onset: _____

History of primary complaint (what happened, improving/worsening, etc): _____

_____

_____

What aggravates your condition? _____

What relieves it? _____

Any numbness or tingling? (where, how often, when, etc.) _____

_____

Previous care for this complaint: _____

Radiographic studies done (MRI, X-rays, arthrograms, ultrasounds, etc): _____

_____

Any other complaints/problems? _____

_____

** What are your goals? _____

Medications – including herbs, supplements, remedies: _____

_____

Allergies: _____

Past Medical History:

___measles
___hypertension
___rheumatic fever
___headaches
___cancer
___mumps
___heart disease
___scarlet fever
___migraines
___depression
___rubella
___kidney disease
___tuberculosis
___Candida
___ulcers
___hives
___UTI
___immune disorder
___glaucoma
___hepatitis
___eczema
___liver disease
___thyroid disease
___heart murmurs
___diabetes
___anemia
___bleeding disorder
___gallbladder disorders
___blood clots
___insomnia
___asthma
___pneumonia
___Epstein Barr
___edema
___stroke
___seizure
___venereal disease
___other (explain below):

_____

_____

_____

_____

Past Surgical History:

___tonsils
___adenoids
___appendix
___uterus
___tooth extraction
___ovaries
___eye
___neck
___chest
___chest
___abdomen
___heart
___gallbladder
___bowel
___breast
___fractures
___stitches/scars
___skin excision
___bunions
___other (explain below):

_____

_____

_____

_____

Hospitalizations:_____

Accidents/trauma/injuries (even as a child): _____

_____

_____

Current exercise/activities/sports: _____

_____

Anything else you feel would be important for me to know? _____

_____

I have read and agree to the following:

Office visit is by appointment only. Your appointment time is set aside for you. If you must cancel or change an appointment, please notify me as soon as possible so that the time may be used to help another person. ***You will be responsible for a cancellation charge of $90.00 for an appointment not cancelled 24 hours in advance.***

You must be under the care of a physician for any existing health problems and are responsible for keeping this office informed of any changes to your health care and/or health problems.

There are additional fees for any records, reports, or evaluations that you might request for insurance or legal purposes, in addition to your treatment.

Signature _____ Date _____