

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. 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:

- | | | |
|--|--|---|
| <input type="checkbox"/> measles | <input type="checkbox"/> Candida | <input type="checkbox"/> bleeding disorder |
| <input type="checkbox"/> hypertension | <input type="checkbox"/> ulcers | <input type="checkbox"/> gallbladder disorders |
| <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> hives | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> headaches | <input type="checkbox"/> UTI | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> cancer | <input type="checkbox"/> immune disorder | <input type="checkbox"/> asthma |
| <input type="checkbox"/> mumps | <input type="checkbox"/> glaucoma | <input type="checkbox"/> pneumonia |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> hepatitis | <input type="checkbox"/> Epstein Barr |
| <input type="checkbox"/> scarlet fever | <input type="checkbox"/> eczema | <input type="checkbox"/> edema |
| <input type="checkbox"/> migraines | <input type="checkbox"/> liver disease | <input type="checkbox"/> stroke |
| <input type="checkbox"/> depression | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> seizure |
| <input type="checkbox"/> rubella | <input type="checkbox"/> heart murmurs | <input type="checkbox"/> venereal disease |
| <input type="checkbox"/> kidney disease | <input type="checkbox"/> diabetes | <input type="checkbox"/> other (explain below): |
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> anemia | |

Past Surgical History:

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> tonsils | <input type="checkbox"/> neck | <input type="checkbox"/> breast |
| <input type="checkbox"/> adenoids | <input type="checkbox"/> chest | <input type="checkbox"/> fractures |
| <input type="checkbox"/> appendix | <input type="checkbox"/> chest | <input type="checkbox"/> stitches/scars |
| <input type="checkbox"/> uterus | <input type="checkbox"/> abdomen | <input type="checkbox"/> skin excision |
| <input type="checkbox"/> tooth extraction | <input type="checkbox"/> heart | <input type="checkbox"/> bunions |
| <input type="checkbox"/> ovaries | <input type="checkbox"/> gallbladder | <input type="checkbox"/> other (explain below): |
| <input type="checkbox"/> eye | <input type="checkbox"/> bowel | |

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 (the current hourly rate) 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 _____