Dana Fonte, MT
Myofascial Release & Craniosacral Therapy
510-524-7845

CLIENT INTAKE FORM

PERSONAL INFORMATION

name | date

home phone | work phone | cell phone

address

city | state | zip | email

birth date | occupation

emergency contact | relationship

how did you hear about dana?

HEALTH INFORMATION

1. What is the primary complaint that brings you here? Please describe your symptoms as specifically as possible.

2. Any secondary complaints you would like to address?

3. How and when did your symptoms begin? For example, did your symptoms begin as a result an accident or injury or did they begin without a known reason?

4. Have you ever received other treatments for this condition? If yes, please indicate the type of treatment and effectiveness.

5. What activities or positions increase your pain and what activities or positions decrease your pain?

6. What are your goals for therapy?

7. Please list any surgeries, accidents or traumas (physical or emotional) and the dates of occurrence.

8. Do you have any implanted medical device?

9. Please list all medications that you are currently taking, the problem for which you are taking them.

10. Are you currently pregnant or is here a possibility you may be pregnant?

11. Please check any of the conditions that you have or have had in had in the past. Mark with a "c" if current and with a "p" if in the past.

MAJOR MEDICAL
Heart Disease
Cancer
High/Low Blood Pressure
Diabetes
Stroke/CVA
Epilepsy/Seizures
Lung Disease
Aneurysm

CIRCULATORY
Hypertension
Edema
Reynaud's Disease
Varicose Veins
Heart Attack
Cardiovascular Disease
Blood Clots
Bleeding Disorder
Diabetes (Type 1 or 2)

DIGESTIVE
Ulcers
Colitis
Gallstones
Hepatitis/Liver Disease
Constipation
Diarrhea
Gas/Bloating
Indigestion/Heartburn
IBS/Cohn's Disease

NERVOUS SYSTEM
Shingles
Multiple Sclerosis
Parkinson's Disease
Bell's Palsy
Spinal Cord Injury
Seizure Disorders
Numbness/Tingling

RESPIRATORY
Pneumonia
Sinus Problems
Allergies
Asthma

SKIN
Fungal Infections
Impetigo
Dermatitis/Eczema
Psoriasis
Cosmetic Surgery

UROGENITAL
Coccyx Pain
Pain with intercourse/Dysparuenia
Cystitis/Chronic UTI
Painful Urination
Frequent Urination
Kidney Disease
Endometriosis
Fibroids
Menstrual Issues

PAIN CONDITIONS
Arthritis (Osteo/Rheum)
Bursitis
Headaches/Migraines
TMJ/Jaw Pain
Low Back Pain
Neck Pain
Knee Pain
Hip Pain/Pelvic Pain
Rotator cuff problems
Sciatica
Pinched Nerve
Thoracic Outlet Syndrome
Carpal Tunnel Syndrome
Plantar Fasciitis
Fibromyalgia
Spasms/Cramps
Sprains/Strains
Tendonitis
Whiplash

OTHER
Osteoporosis
Hernia
Difficulty Sleeping
Tinnitus
Sleep Apnea
Dizziness/Vertigo
Anxiety/Panic Attacks
Depression
Thyroid Condition
HIV
Lupus

CONSENT TO TREAT

I give Dana Fonte permission to provide treatment that will include manual therapy and therapeutic exercise. I understand that in order for me to fully benefit from the treatment provided, I will have to participate on my own behalf outside of my treatment sessions. This might include performing self-myofascial treatment, to progress my healing process.

In order for my therapist to most effectively treat me with manual therapy, I may be asked to remove some clothing or wear little clothing during treatment. I understand that if I am uncomfortable with this, I will share my concerns with my therapist and she will bide by my request.

I acknowledge that Dana Fonte must be fully aware of my existing medical conditions. I have completed the client intake form and have disclosed, to the best of my knowledge, all of the medical conditions affecting me. It is my responsibility to update my therapist on my medical history.

I have read the above noted consent. By signing this form, I consent to treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Signature_____Date_____

CANCELLATION POLICY

I understand that each appointment I have scheduled is very important either for my own treatment process or that of another who could potentially fill the time slot. I agree to notify Dana Fonte within 24 hours if I need to cancel an appointment. If I am unable to do this I understand that I will be responsible for payment for the scheduled time unless Dana is able to fill the appointment time.

I have read and understand this cancellation policy.

Signature_____Date_____

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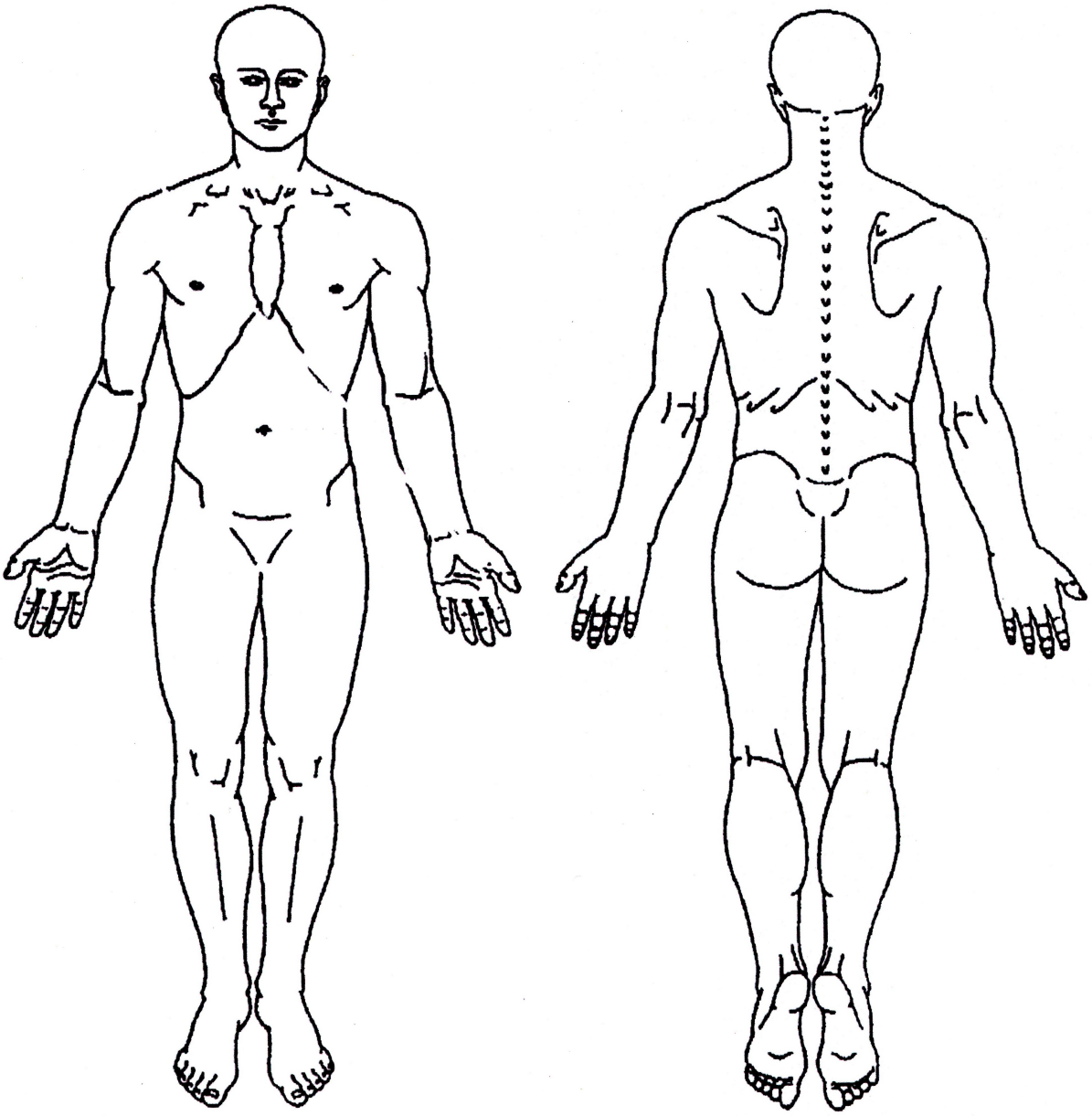
Client Intake Diagram

Please identify areas of soreness or pain with a (P), numbness or tingling (N), weakness (W), and scars (S):



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