7408 Silent Willow Ct.
Manassas, VA 20112
703-919-3989
www.pro-activewc.com

INITIAL EVALUATION FORM

The following is a very important part of the evaluation process. Please fill out this form as specific as possible to provide your therapist and trainer with a clear picture of your present pain and functional status. Thank you.

Date: M/D/Y________________________

Full Name ____

Phone #: Day __________________ Evening __________________

Address: ________________________________ Apt. #: ________

City: _________________________ State: _____ Zip: _________

Email address: ____

Date of Birth: _________ Age:_______ Gender: ________ Occupation: __________________

Emergency Contact: _____________________ Relationship: ___________ Phone #: _________

How did you hear about us? ____

GENERAL MEDICAL INFORMATION

Primary Physician: _______________ Location: ___________________ Phone #: ___________

What is your reason for your visit today? ____

____

____

Are you or have you been treated for your current condition and if so please explain the type of treatment you are/have received and the duration of the treatment. Y/N ______________________

____

____

What would you like to see achieved with your mfr therapy /wellness program? ________________

____

____

Please check the following conditions/illnesses that you have either had in the past or currently have:

☐Cardiovascular Disease
☐Arthritis (Osteo /Rheum)
☐Asthma/Respiratory
☐Vertigo / Dizziness
☐Thyroid (Hypo/Hyper)
☐Drug or Alcohol
☐Osteoporosis
☐Heart Murmur
☐Weight changes
☐HIV/AIDS
☐Migraines /Headaches
☐Broken Bones
where___________ when_____________
☐Cancer - Type __________ Location________
Year___________ status______________
☐Allergies (latex, food, seasonal, medicine)
☐Obesity

☐High Blood Pressure
☐Kidney/Renal Disease
☐Congestive Heart Failure
☐Hepatitis/Liver Disease
☐Neurological Condition
☐Depression/Anxiety
☐Chronic Infections
☐Varicose Veins
☐Metal Implants (explain)
☐Stroke or Heart Attack
☐Diabetes (1 or 2)
☐MS
☐Fibromyalgia
☐Epilepsy/Seizures
☐Fainting or Blackouts
☐Eating disorder

Do you have any implanted medical devices such as a pacemaker, insulin pump, or internal defibrillator? Y/N ____

List past medical history (surgeries, injuries, accidents or other traumas with dates)

____

____

Please list all medications you are presently taking, including the dose, reason for the medication and effectiveness. ____

____

____

Are you currently pregnancy or is there a possibility you might be pregnant? Y/N _______________

Do you smoke? Y/N How much? ____
Do you currently exercise? Y/N ____

If so please list type of exercise and duration:
Activity ______________________ How many times a week?_______ Duration of time______
Activity ______________________ How many times a week?_______ Duration of time______
Activity ______________________ How many times a week?_______ Duration of time______
Do you experience discomfort or shortness of breath with these activities? Y/N _______________

How would you characterize your present lifestyle?

☐Very Active ☐Active ☐Average ☐Somewhat Average ☐Inactive

Do you have trouble falling asleep or sleeping in general? Y/N ______________________________
Please describe: ____

Please estimate the amount of time, on average each day that you spend in the following activities:

Sleeping ____________________
Computer Work _______________
Sitting at a desk _______________
On the phone _________________
Sports/Hobbies ________________

Working ________________
Driving _________________
Standing_________________
Household Chores ________
Other (heavy yard work/farm work)
____

Do you feel tired during the day? Y/N

Do you have trouble with everyday activities? getting up and down from a chair, bending over, going up and down stairs, getting in and out of your car, etc) Y/N

Please explain: ____
____
____

What are your goals for your therapy and fitness programs? State in positive form sentences (for example: My goal is to be able to go hiking with my kids by next spring)

____
____
____

NOTE: Please check with your primary doctor before starting any exercise program. Thank you.

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I HAVE SHARED ABOVE IS COMPLETE AND TRUE. IF MY MEDICAL AND HEALTH STATUS CHANGES, I WILL INFORM MY MFR THERAPIST/TRAINER IMMEDIATELY.

CLIENT SIGNATURE __________________________________DATE: _________________

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CONSENT FORM AND CANCELLATION POLICY

Please take a moment to read and initial the following information:

I understand that myofascial release therapy is a technique that helps in reduction muscle tensions, pain and/or restrictions in range of motion. Myofascial release can release emotional tension as well. Pain can be stressful and when the body is released of pain, the mind is released from the stress of dealing with constant pain. I understand that my emotions are a natural response and an important part of the healing process. If I experience pain or discomfort during the session, I will communicate with my therapist during the session as to what I am feeling.

I affirm that I have notified my therapist of all known medical conditions and injuries. I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so. I understand that myofascial release or massage therapy is entirely therapeutic and non-sexual in nature.

I am aware that along with the myofascial release therapy, self-treatment, stretching, and exercises recommended by my therapist /trainer (LMT, CPT) can accelerate my recovery and have long term results in reducing and eliminating pain.

By signing this release, I hereby waive and release my therapist and Pro-Active Wellness, Inc. from any and all liability, past, present, and future relating to myofascial release therapy, massage therapy, bodywork, as well as any exercises/fitness program that maybe recommended by my therapist/trainer.

I understand that PROACTIVE WELLNESS CONCEPTS requires 24 hour notification if I am unable to keep my appointment. I understand that if I fail to do so, I will be charged a "cancellation/missed appointment fee" of $25. I also understand that if I arrive late, I will receive the remainder of my time but will be responsible for payment in full.

I have received the policy statement, and have read and agree to the policies there

CLIENT SIGNATURE:________________________________ DATE:__________________

Please read this information sheet explaining myofascial release prior to your visit.

Information about Myofascial Release Therapy

What is Myofascial Release? Myofascial Release is a safe and very effective hands-on technique that involves applying gentle sustained pressure into the Myofascial connective tissue restrictions to eliminate pain and restore motion. This essential "time element" has to do with the viscous flow and the piezoelectric phenomenon: a low load (gentle pressure) applied slowly will allow a viscoelastic medium (fascia) to elongate.

Trauma, inflammatory responses, and/or surgical procedures create Myofascial restrictions that can produce tensile pressures of approximately 2,000 pounds per square inch on pain sensitive structures that do not show up in many of the standard tests (x-rays, myelograms, CAT scans, electromyography, etc.).

The use of Myofascial Release allows us to look at each patient as a unique individual. Our one-on-one therapy sessions are hands-on treatments during which our therapists use a multitude of Myofascial Release techniques and movement therapy. We promote independence through education in proper body mechanics and movement, self treatment instruction, enhancement of strength, improved flexibility, and postural and movement awareness.

Hands-On Treatment

Each Myofascial Release Treatment session is performed directly on skin without oils, creams or machinery. This enables the therapist to accurately detect fascial restrictions and apply the appropriate amount of sustained pressure to facilitate release of the fascia.

- MFR is given while you remained clothed. We ask that you wear fitness clothes for better range of motion. You will be asked to remove your shoes, in some cases socks will be removed.
- Feel free to ask your MFR therapist any questions before, during, or after the session. Your therapist is a highly trained professional and will be happy to make you feel informed and comfortable.
- MFR should not be painful, generally speaking, but please advise your therapist if certain areas are more painful than others. After completing your session, your therapist may give you some exercises/stretches/relaxation exercises specifically related to your needs. Your success in having long term results will depend on how well you keep up with your program.
- Please drink plenty of water after your session to release any toxins that may be in your muscles.
- You may experience muscle soreness up to 48 hours after your MFR session, but this is normal.
- Women: please avoid wearing bras that have wire. Soft casual bras, or athletic bras are recommended.
- Remove all jewelry prior to your session (earring, bracelets, rings, hair clips, etc.).

During your session you may experience the warmth of your therapist's hands. Some muscle contractions are mild, this is normal and is a sign that your body is healing.