Dhyana Moyer LMT, JSCC
Specializing in Fascial Counterstrain

Bainbridge Island | (206) 605-3949

INFORMED CONSENT FOR TREATMENT

I voluntarily consent to the procedures of fascial counterstrain services, realizing that Dhyana Moyer, LMT, has given no guarantees to me regarding cure or improvement of my condition. I hereby release Dhyana Moyer, LMT, from any and all liability that may occur in connection with fascial counterstrain. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself, or unless required by law. I understand that I may look at my records and request a copy. I understand that my practitioner will answer any questions that I have.

I understand that any cancellation must be no less than 24 hours prior to the scheduled appointment to avoid charges for the visit, except in cases of medical emergency.

____

Signature of patient or guardian

______________________________ ______________

Printed name of patient Date

INTAKE FORM

Initial Appointment Date_____________

Last Name_____________________ First Name_________________________

Address____

City_________________ State______ Zip_______________

Home Phone (______)________________ Work (______)________________

Cell (______)__________________

E-mail (office use only)______________________________ Fax (____)___________

Local Contact Information (if different)__________________________________

Occupation____

Date of Birth ________________________ Height_________ Weight_________

Sex _______

Marital Status: Single Married Partnered Divorced Separated Widow(er)

Spouse/Partner Name (if applicable) ____

Who referred you? ____

A note on Health Insurance

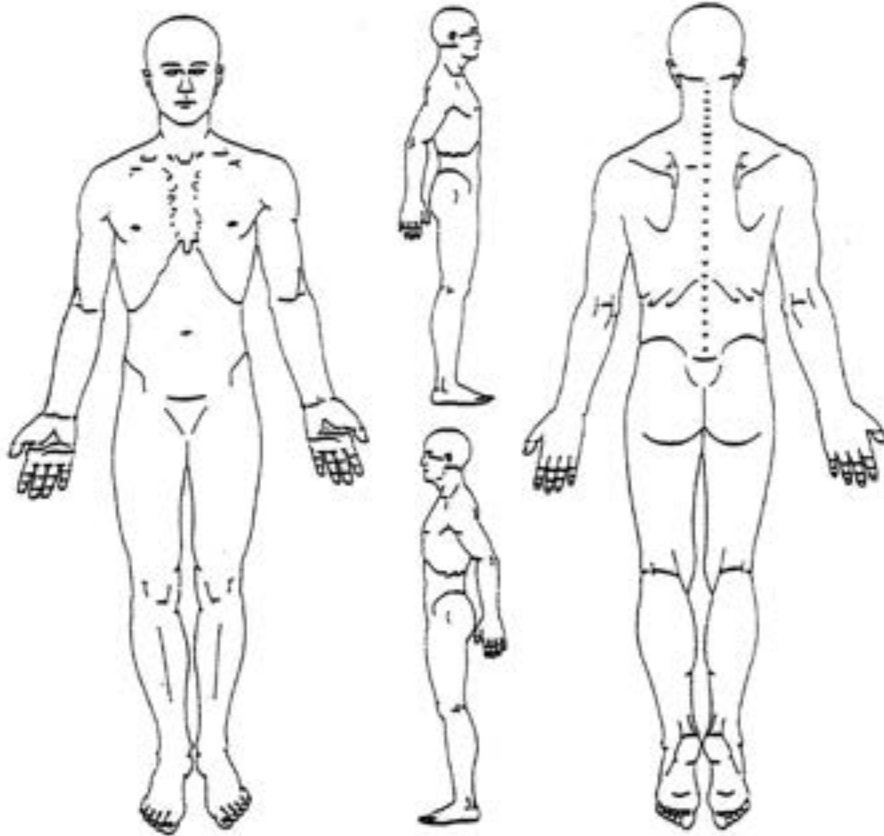
I do not take health insurance for my services but many of my clients get reimbursed by their health insurance companies for them.

*Whenever possible, get a referral from your physician for **manual therapy** or **massage therapy**, this will increase your chances to get reimbursed. Your physician is also kept informed about your progress with appropriate reports.*

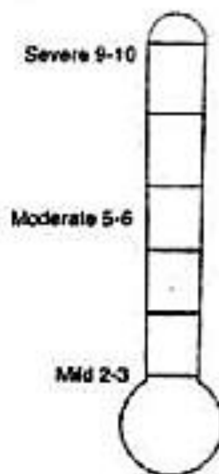
Please make sure to speak with your Health Insurance provider to find out the details and address your questions.

Please give a 24 hour cancellation notice if you can not make an appointment at (206) 605-3949

Where exactly is the problem? Outline your discomfort in red



Rate the recent level of pain by shading in the thermometer below.



Has it been getting *BETTER* **or** *WORSE?* **(Circle one)**
Describe how it feels: *(aching, cramping, dull, sore, deep, sharp, shooting, stabbing, stinging, tingling, burning, numbness, radiating* **- if so where?***)*

How did it start the first time and this time, if this is not the first? *(Sudden or gradual onset and mechanism of injury)*

How often does it bother you?

- ☐ Constant all the time
- ☐ Everyday
- ☐ _____x per week
- ☐ _____x per month

How long does it last once it is there?

- ☐ Always there
- ☐ _____ minutes/hours
- ☐ No pattern

What specifically makes it worse?

- ☐ Certain movements/activities
- ☐ Stress
- ☐ Time of day
- ☐ No pattern

What makes it feel better?

- ☐ Certain movements/activities
- ☐ Heat/ice
- ☐ No pattern
- ☐ Time of day
- ☐ Therapies
- ☐ Nothing

Do you have a diagnosis from a Doctor? If, yes please list it.

Other therapies/remedies tried and results:

Have you ever had any surgeries and were they beneficial at the time?

List any other health problems for which you are being treated:

Do you have any preexisting conditions that relate to this present injury?

☐ Yes ☐ No

If yes, please explain:

What do you believe caused or is causing this condition?

What are your goals for your health and your well being?

General Medical History

- ☐ Arthritis
- ☐ Allergies
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal Tunnel syndrome
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental Problems
- ☐ Diabetes
- ☐ Diverticular Disease
- ☐ Drug addiction
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Infection, chronic
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel Syndrome
- ☐ Kidney or Bladder Disease
- ☐ Liver or gallbladder disease (stones)
- ☐ Migraine Headaches
- ☐ Neurological problems (paralysis, Parkinson's)
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Ulcer
- ☐ Urinary Tract Infection
- ☐ Varicose Veins
- ☐ Other

Health Habits

- ☐ Tobacco
- ☐ Cigarettes # /day
- ☐ Cigars #/day
- ☐ Alcohol
- ☐ Wine: # glasses/ d or wk
- ☐ Beer: # glasses/ d or wk
- ☐ Liquor: # ounces/ d or wk
- ☐ Coffee: # 6 oz cups/ d
- ☐ Tea: # 6 oz cups/ d
- ☐ Soda w. Caffeine: # cans/ d
- ☐ Other Sources
- ☐ Water: # glasses/ d

Current Supplements

- ☐ Multivitamins
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening Primrose/ GIA
- ☐ Calcium, source
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals, describe
- ☐ Friendly Flora (acidophilus)
- ☐ Digestive Enzymes
- ☐ Amino Acids
- ☐ CoQ10
- ☐ Antioxidants (e.g. lutein, resveratrol, etc.)
- ☐ Herbs (teas)
- ☐ Herbs-extracts
- ☐ Chinese Herbs
- ☐ Ayurvedic herbs
- ☐ Homeopathy
- ☐ Bach Flowers
- ☐ Protein Shakes
- ☐ Super-foods (e.g. bee pollen,
- ☐ Phylonutrient blends
- ☐ Liquid Meals (e.g. Ensure)
- ☐ Other: