Restrictions Released
Myofascial Therapy

Patient Registration

First Name		Last Name	
Date of Birth		Sex	M F

Address

Street					
City		State		ZIP code	

Contact Information

Home phone		Cell phone	
Email address			

Medical Contacts

Primary care physician	
Referring doctor *(if applicable)*	

Emergency Contact

Name	
Relation	
Phone number	

Medical History

List all past surgeries and approximate date of surgery

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List all medications you are currently taking

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Patient Name: ______________________________

Indicate if you have a history of any of the following

Past Medical History	Yes	No	Symptoms	Yes	No
Angina			Chills		
Abdominal aortic aneurysm			Chest pain		
Anxiety			Changes in bowel		
Asthma/bronchitis			Changes in bladder		
Bladder sling			Depression		
Blood clots			Dizziness		
Cancer			Excessive thirst		
Depression			Fainting		
Diabetes			Fever		
Fibromyalgia			Headaches		
Gastroesophogeal reflux			Loss of balance		
Gout			Nausea / vomiting		
Heart disease (specify)			Numbness		
Hernia / hernia repair			Rash or skin changes		
High blood pressure			Shortness of breath		
Kidney or liver disease			Sleep loss		
Multiple sclerosis			Swelling of extremeties		
Pacemaker			Unexplained weight loss		
Parkinson's disease			Other (explain below)		
Rheumatoid arthritis					
Stroke					
Seizures			**Pregnancies (women only)**	**#**	
Thyroid disease			Number of pregnancies		
Ulcers			Number of C-sections		
Other (explain below)			Number of vaginal births		

Other

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