HEALING MFR INTAKE FORM
516 SE CHKALOV DR SUITE 49
VANCOUVER, WA 98683

PATIENT INFORMATION			
First Name:	**Last Name:**	**Middle Initial:**	**Mr. Miss Mrs. Ms.**
Address:		**Birth date:**	**Sex:**
City/Province			**Postal Code:**
Email Address:			
Home Phone:	**Cell Phone:**	**Work Phone:**	
Physician name:		**Occupation:**	
Insurance Comp/Policy Number:			

Choose clinic because/referred to clinic by (Please check one box):
Doctor referral Health Plan Hospital Close to home/work Online Family Friend Other
If a friend referred you to us please let us know who so we can thank them:
Reason for Visit:

CONDITION INFORMATION					
Are you experiencing pain? Yes No					
If you are experiencing pain, is it: Shooting Sharp Stabbing Throbbing Achy Burning Dull					
How would you classify your pain level on a scale of 0 (minimal) – 10 (unbearable)? 0 1 2 3 4 5 6 7 8 9 10					
When did it start?					
What relieves the condition? **What aggravates the condition?**					
Is the condition getting better? Yes No Constant Comes and Goes					
Have you seen a:	**Chiropractor**	**Massage Therapist**	**Acupuncturist**	**Physician**	**Other**
For what condition and when?					
Have you had any surgery? Yes No	**For what part and when?**				
Are you presently taking any medication? YesNo	**If yes, please give name and what it's for:**				

A *24 HRS NOTICE* OF AN APPOINTMENT CHANGE/CANCELLATION IS REQUIRED (OR BY 12PM ON SATURDAYS FOR MONDAY APPOINTMENTS), OR A $100 FEE WILL BE CHARGED*

CONSENT FOR ASSESSMENT AND TREATMENT AND RELEASE OF INFORMATION

I hereby give Katherine Allen LMP to treat me as such as a medical professional at Healing MFR.

I consent to the sharing of information regarding these assessments and treatments between members of the treatment team and my doctor/specialist, if necessary.

I also realize that I may choose to communicate via text my medical information.

This represents a written authorization that I am allowing Katherine Allen of Healing Myofascial Release to work on my breast tissue, perform breast tissue massage and external pelvic floor work such as working the adductors (inner thighs) glutes, sacral coxageal area, SI Joints. I understand that when these areas are worked on that the glutes or the breast tissue may be exposed. I also understand that this is for Therapeutic purposes only and that if any sexual act or sexual commets are starting to take place by the client the therapist will terminate the session immediately and no refunds will be and the client will NOT be allowed to come back to Healing MFR. I am giving my consent to treat and I also understand that if at any time during the session if I feel uncomfortable I will be able to end the session immediately or end the work and ask to be worked on in a different area.

Patient signature:_____
Date:_____