REAL RELIEF
Myofascial Release, LLC

# New Patient-Client Information & Medical History

Name:
Occupation:
Referred By:
Gender:
DOB: Age:
Emergency Contact (name, phone, relationship):
Mailing Address:

========= **COMMUNICATION METHODS & PERMISSIONS** ======

Phone: Is this a cell phone? Y N
*Permission to Call? Y N Any hours *not* to call?
*Permission to Text? Y N Any hours *not* to text?
Email:
*Permission to send nonencrypted (regular) emails? Y N

*Permission to take Photographs (as described in your signed Informed Consent form): Y N
* Permission to email your nonencrypted photographs to you if you ask me to use my phone? Y N

Regular phone, text, and email communications do not protect your Privacy Rights.
Please sign and date to indicate your permission and preferences for communication and photography as selected above:

Signature: _____ Date: _____

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Last Physical Exam:
Other Healthcare Providers:
Medications & Supplements (include over-the-counter and pain medications):

Implants (pacemaker, mesh, etc.), Hearing Aids, Wig, Prosthesis? Y N Specify:

Drug allergies: Latex Allergy? Y N
Height: Weight: Right-handed ____ Left-handed ____

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Patient Name: _____

CHIEF COMPLAINT (Reason for today's visit)

Treatment GOALS: (What does this issue make it difficult for you to do in daily life?)

LIST and SCORE your PAIN/DISCOMFORT (up to 3 main areas- A,B,C)
(Details of pain/discomfort are hard to describe for almost everyone; just do your best)

A-_____ B-_____ C-_____

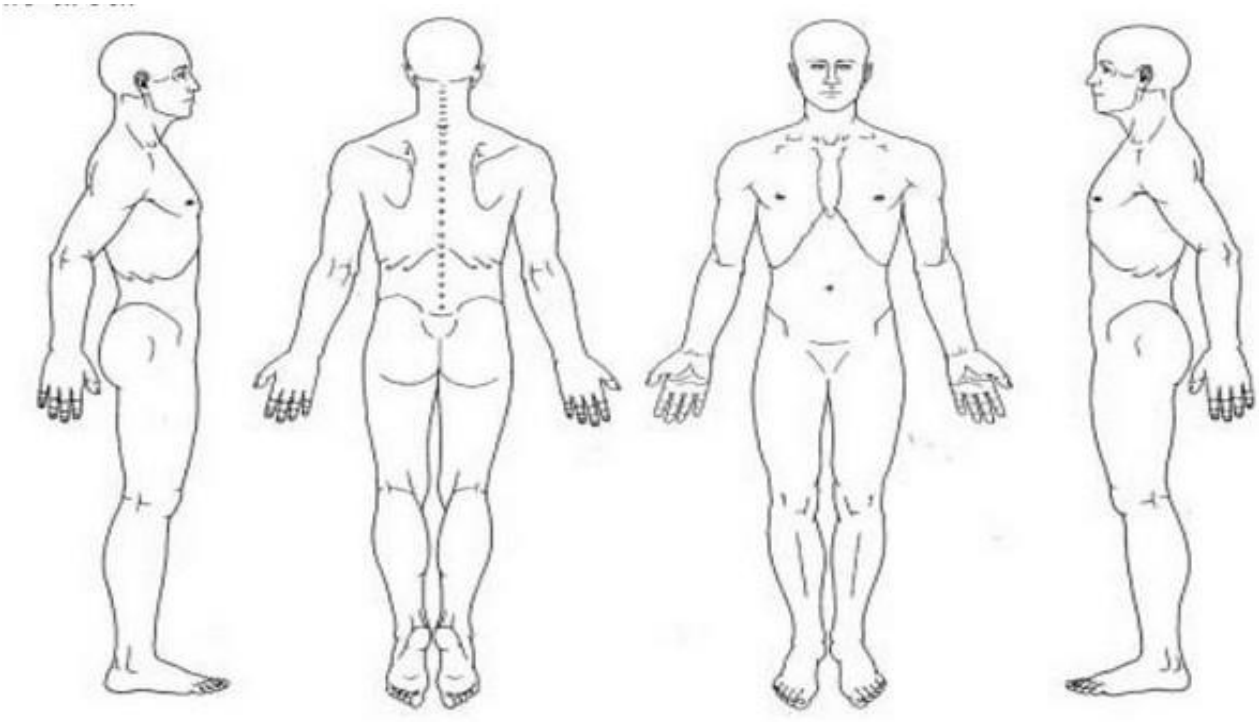
**Pain Score:** (0 to 10)

**Now**: A-____B-____C-____ At its **worst**: A-____B-____C-____ At its **best**: A-____B-____C-____

% of the day: A-____B-____C-____ % of the day: A-____B-____C-____

What makes it better? A-_____ B-_____ C-_____

What makes it worse? A-_____ B-_____ C-_____



SURGICAL HISTORY, OTHER PROCEDURES, FRACTURES, OTHER INJURIES, SCARS
(include "scope" surgeries, cosmetic procedures, implant, mesh, deliveries, other pregnancy-related procedures)

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Patient Name: _____

**REVIEW OF SYSTEMS** (diseases; conditions or symptom of any organ or body part):

Current overall health (your opinion): __Excellent __Very Good __Good __Fair __Poor
Are you pregnant? _____
Mental Health:

**SOCIAL HISTORY**
Occupation/Employment (current and/or previous):
Hobbies/Usual Activities:
Living Situation (marital status, type of housing, people, pets, support, stress):
Diet:
Sleep:
Exercise:
Alcohol: Tobacco: Recreational Drugs:
Religious/ Spiritual:
Victim of Domestic Violence/ Sexual Assault/ other violent crime:
Military Service:
Life-Altering Events/Trauma:

Are you currently involved in a Worker's Compensation claim, automobile insurance claim, personal injury lawsuit, or medical malpractice claim related to an injury or accident that you experienced?
Y N Details:

ACKNOWLEDGEMENTS
- I understand that all details of my medical history may be important for Dr. Harris to be aware of, and that it would be helpful to provide copies of any pertinent radiologic reports, specialist consultations, or test results.
- I also understand that it would be best to report at the time of future appointment(s) any changes to any of the information provided in this form.
- I have either completed this form myself, or Dr Harris has completed it when she discussed my medical history with me, and I understand that she may also add details at a later time that I omitted today, as we continue in the future to discuss my medical history.

Patient-Client Signature: _____ Date: _____

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version ABC-IYH 9-9-2024