



300-205D Copperfield Blvd., Copperfield Plaza
Concord, North Carolina 28025
Phone: 980.621.MFR3 (6373)
www.flowMFR.com
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Advanced Myofascial Release Center

INITIAL EVALUATION

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

Personal Information (Please print clearly)

Date:

Name: _____
Last First Middle Initial

Home Address: _____
Street City State Zip

Telephone: Home: (____) _____ Mobile: (____) _____ Work: (____) _____

Date of Birth: _____ Age: _____ Sex: _____ E-Mail Address: _____

Occupation: _____ Currently Working: Yes No F/T P/T

Medical Information

Primary Physician: _____

Address: _____ Phone: _____

Referring Physician or Therapist: _____

Address: _____ Phone: _____

Who referred you to Flow Advanced Myofascial Release Center? (if other than your Physician):

1. What is the PRIMARY complaint that brings you to Flow Advanced Myofascial Release Center today?

SECONDARY complaint?

As a result, I am having difficulty with.....

Are you experiencing pain as a result of these symptoms?

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2. When (date) and how did your symptom(s) begin? _____

3. Have you ever received any of the following treatment(s) for this condition?

	Yes	No	How Long?	Helpful / Manage / Resolve
Physical Therapy	_____	_____	_____	_____
MFR	_____	_____	_____	_____
Chiropractic Care	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____
Trigger Point Injection(s)	_____	_____	_____	_____
Other _____	_____	_____	_____	_____

4. Please check any / all illnesses you have either had in the past or currently have:

- _____ Cardiovascular disease
- _____ High Blood Pressure
- _____ Diabetes (I or II)
- _____ Arthritis (Osteo / Rheum)
- _____ Kidney / Renal disease
- _____ Multiple Sclerosis
- _____ Asthma / Difficulty Breathing
- _____ Congestive Heart Failure
- _____ Fibromyalgia
- _____ Dizzy / Vertigo
- _____ Hepatitis / Liver Disease
- _____ Epilepsy / Seizures
- _____ Thyroid Condition (Hypo / Hyper)
- _____ Neurological Condition
- _____ Eating Disorder
- _____ Drug or Alcohol Abuse
- _____ Depression
- _____ Anemia
- _____ Osteoporosis
- _____ Chronic Infections
- _____ Lupus
- _____ Heart Murmur
- _____ Varicose Veins
- _____ Blackouts
- _____ Weight Change
- _____ Metal Implants (if so, where _____)
- _____ HIV/AIDS
- _____ Stroke or Heart Attack (If so, when _____)
- _____ Migraines / Headaches - (If so, how frequent _____)
- _____ Broken Bone(s) - (if so, where and when _____)
- _____ Cancer - Type _____ Location(s) _____
- Year _____ Status _____
- _____ Allergies - (Latex, Food, Seasonal, Medicine) _____
- _____ Other - (Please specify) _____

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5. Do you have a pacemaker, internal defibrillator, insulin pump, or any other implanted medical device?

6. List past medical history with dates for all surgeries, accidents and other traumas.

7. Please list ALL medications you are presently taking, the dose, the reason for each medication and the effectiveness. (ie: Prozac for Depression, Ultram for Pain, Accupril for High Blood Pressure)

<u>Medication</u>	<u>Treatment of</u>	<u>Dose / Amt per Day</u>	<u>Effectiveness</u>
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8. Please list all supplements, herbal and homeopathic remedies you are presently taking.

9. Are you currently pregnant or is there a possibility you may be pregnant? Y / N

10. Do you smoke? Y / N Cigar / Cigarette / Pipe How Much? _____ Quit? Y / N

11. Do you currently exercise and/or participate in any sports? Y / N

<u>Activity</u>	<u># Times per Wk / Mo</u>	<u>Duration of Time</u>
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12. Do you experience any discomfort, shortness of breath or pain with these activities? Y / N

13. In general, how would you characterize your lifestyle? 1 2 3 4 5
Active Average Inactive

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14. Please review the following "symptoms".

Place an "M" in front of each item that you experience at least MONTHLY.

Place an "W" in front of each item that you experience on a WEEKLY or more frequent basis.

- | | |
|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Feeling of inadequate / unable to cope |
| <input type="checkbox"/> Chest pain, tightness | <input type="checkbox"/> Feeling guilty of like a failure |
| <input type="checkbox"/> Numbness, tingling in arms and legs | <input type="checkbox"/> Uncontrolled crying or sadness |
| <input type="checkbox"/> Sweaty palms | <input type="checkbox"/> Easily annoyed or irritated |
| <input type="checkbox"/> Excessive perspiration | <input type="checkbox"/> Anxiety about life |
| <input type="checkbox"/> Can't keep warm enough | <input type="checkbox"/> Blushing / Flushed face |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Eyestrain or discomfort |
| <input type="checkbox"/> Stuffy nose, congestion | <input type="checkbox"/> Eye irritation or inflammation |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Visual disturbances - blurry |
| <input type="checkbox"/> Earache or ringing noise in ears | <input type="checkbox"/> Stomach cramps |
| <input type="checkbox"/> Common Colds | <input type="checkbox"/> Heartburn / Indigestion |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Nausea or vomiting |
| <input type="checkbox"/> Asthma or shortness of breath | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Hay fever or allergies | <input type="checkbox"/> Incomplete urination |
| <input type="checkbox"/> Sore, aching muscles | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Stiff or tender joints | <input type="checkbox"/> Urinary leakage |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Bowel leakage |
| <input type="checkbox"/> Trembling / twitching muscles | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Skin rashes, eruptions | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Grinding of teeth (TMJ) | <input type="checkbox"/> Bowel irregularity |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Frequent laxative use |
| <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Uninterested in sex relations |
| <input type="checkbox"/> Trouble falling asleep | <input type="checkbox"/> Unable to enjoy sexual activity |
| <input type="checkbox"/> Difficulty sleeping through the night | <input type="checkbox"/> Menstrual difficulties |
| <input type="checkbox"/> Awaken too early in morning | <input type="checkbox"/> Pre-menstrual syndrome |
| <input type="checkbox"/> Excessive drowsiness during day | <input type="checkbox"/> Breast tenderness |
| <input type="checkbox"/> Periods of extreme fatigue | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Feeling faint or dizzy | <input type="checkbox"/> Water retention |
| <input type="checkbox"/> Feeling tense or nervous | <input type="checkbox"/> Over-eating, bingeing |
| <input type="checkbox"/> Difficulties w/family and friends | <input type="checkbox"/> Lack of appetite |
| <input type="checkbox"/> Worrisome thoughts | <input type="checkbox"/> Excessive alcohol abuse |
| <input type="checkbox"/> Recurring bad thoughts | <input type="checkbox"/> Other substance abuse |
| <input type="checkbox"/> Thoughts of suicide | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Fearful of persons or places | _____ |

15. If sleep is a problem, do you have trouble falling asleep? Y / N

Is your sleep restful? Y / N

Do you find it difficult to lay down? Y / N

Do you have difficulty sitting up from a lying down position? Y / N

Do you have difficulty changing positions in bed? Y / N

How many times do you wake up during the night? _____

How long does it take you to fall back asleep? _____

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16. Please rate the *INTENSITY* of your pain with “0” being no pain, “5” being moderate pain and “10” being unbearable pain.

0 _____ 5 _____ 10 _____

17. Please rate the *FREQUENCY* of your pain with “0” being never, “5” being intermittent and “10” being constant.

0 _____ 5 _____ 10 _____

18. Using the same “0-10” scale, rate your pain.

At its worse _____ At its best _____ Most of the time _____ Night/Sleeping _____

19. What time of day are your symptoms the *WORST*? _____

20. What time of day are your symptoms the *BEST*? _____

21. What activities *INCREASE* your pain? _____

22. What activities *DECREASE* your pain? _____

23. Please estimate the amount of time, on average per day, you spend on the following activities:

_____ Sleeping _____ Driving _____ Household Chores
_____ Working _____ Sitting at Desk _____ Standing in Place
_____ Computer Work _____ Talking on the Phone _____ Playing (Sports / Hobbies)
_____ Other _____

24. Do you need to rest during the day? Y / N If so, how often and for how long? _____

25. How much time can you tolerate being in a vertical position each day? _____ Hour(s)
(Include sitting, standing, driving and walking)

26. How much time can you tolerate being in a horizontal position each day? _____ Hour(s)
(Include reclining, laying down, sleeping)

27. Please complete the following sentences:

I can walk for _____ minutes before needing to rest.
I can stand for _____ minutes before needing to rest.
I can sit for _____ minutes before needing to change positions or get up.

28. Do you have trouble getting up from a chair? Y / N

29. Do you have trouble putting on your shoes and socks? Y / N

30. Do you have difficulty climbing stairs? Y / N

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31. Please list all the tasks and/or activities that you have difficulty performing. Include the amount of time that you are able to perform each activity and/or task. If you are unable to perform an activity and/or then your tolerance would be "0".

Task / Activity	Tolerance (Minutes/Hrs)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

32. On the line below, place a mark to indicate your level of daily functional ability.

GOOD DAY:

Inactive

Active

BAD DAY:

Inactive

Active

33. What are your goals for therapy? Please be specific.

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

Signature

Date

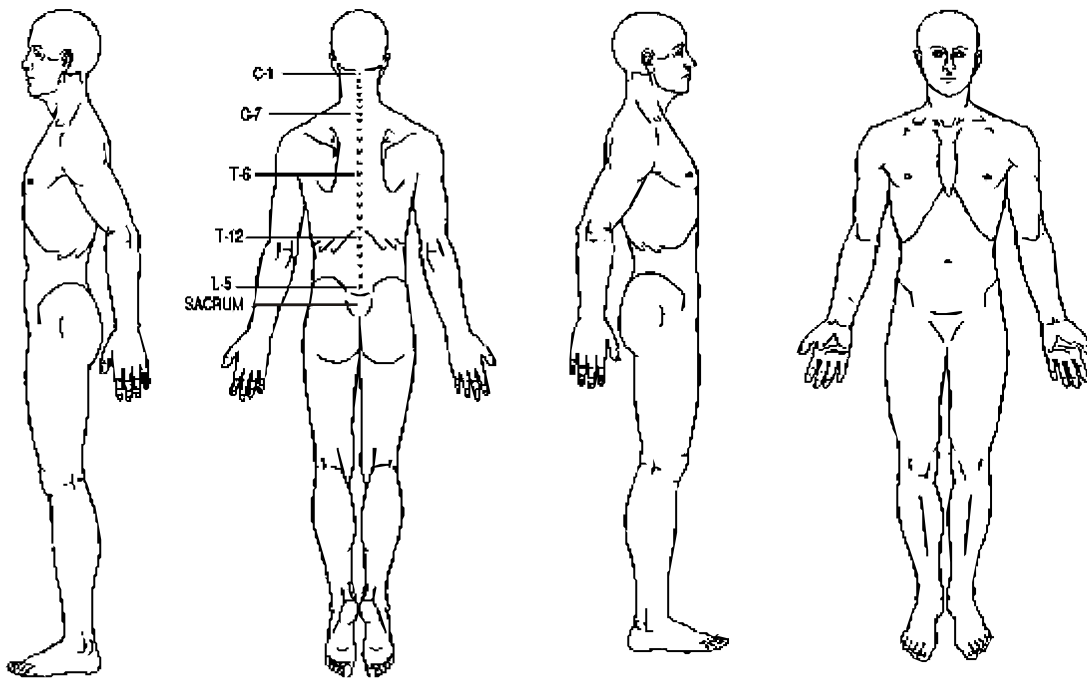
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Draw / Color Your Pain, Discomfort and Tension

Using a highlighter, please clearly mark all areas of pain, discomfort and/or tension on the body chart below.



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