MYOFASCIAL RELEASE® MFR TREATMENT CENTERS & SEMINARS

Therapy On The Rocks
676 N State Route 89A
Sedona AZ 86336
928-282-3002
www.therapyontherocks.net

INITIAL EVALUATION SUBJECTIVE REPORT

Name _____ Date _____

How do you prefer to be addressed? _____ Age _____

Occupation _____ Height _____ Weight _____

Address _____

Phone/Fax _____ E-Mail Address: _____

How did you hear about us? _____

Referring Physician _____

Address _____

Phone/Fax _____

Referring Therapist _____

Address _____

Phone/Fax _____

The following is very important to our evaluation process.
Please fill out these forms as specifically as possible to provide us with a clear picture of your present symptoms, abilities, and goals.

1. **What is the primary complaint that brings you here to Therapy on the Rocks?**
   Please describe your symptoms as specifically as possible.

_____

_____

2. **Secondary complaint?** _____

_____

3. **On what date did your symptoms begin?** _____

4. **How did your symptoms begin?**
   For example, did your symptoms begin as a result of an accident or trauma, or did they begin without a known reason?

_____

_____

5. **Have you ever received the following treatment for this condition?**
   If yes, please indicate length of treatment and effectiveness.

Physical Therapy _____

MFR _____

6. Put a slash mark on the line below to indicate the **INTENSITY** of your symptoms:

None _____ Worst Possible

7. Put 2 slash marks on the line below to indicate the **BEST** and **WORST** your symptoms have been in the past week:

None _____ Worst Possible

8. Put a slash mark on the line below to indicate the **FREQUENCY** of your symptoms:

Never _____ Constant

9. **What activities increase your pain?**

10. **What activities decrease your pain?**

11. On the lines below, place a slash mark to indicate your daily functional ability as a percentage of normal:

On a “good day” 0% _____ 100%

On a “bad day” 0% _____ 100%

12. For each activity listed below, please note the amount of time in minutes or hours that you can perform before you feel that you need to stop because of your symptoms. If you have no difficulty with the activity, mark OK; if you are unable to perform the activity, mark UNABLE; if this does not apply to you, mark NA.

Activity	Tolerance	Activity	Tolerance
Sitting		Computer Work	
Standing		Exercise	
Walking		Writing	
Stairs (# of stairs/flights)		Shopping	
Driving		Bending	
Sleeping		Reaching (# of repetitions)	
Lifting (# of pounds)		Carrying (# of pounds)	
Other		Other	
Other		Other	

13. **What are your goals for this treatment program?** For example, what activities from the above list would you like to be able to perform better or longer? How long in minutes or hours do you need or want to perform each activity?

14. **Do you have any of the following medical conditions?**

	Yes	No		Yes	No
Circulatory problems			Blackouts		
High blood pressure			Visual disturbances		
Heart trouble			Weight changes (>15lbs)		
Pacemaker			Headaches		
Epilepsy			Ringing in the ears		
Diabetes			Bowel/bladder problems		
Pregnancy			Malignancy		
Stroke			Other		

15. **Past Medical History:** Please list any surgeries, traumas, accidents or other conditions and the dates of occurrence.

16. Please place a check in front of each item that you experience at least monthly. Place an X in front of each item that you experience weekly or more frequently.

_____Headache
_____Heart pounding or racing
_____Irregular heartbeat
_____Chest pain, tightness
_____Numbness, tingling in arm or leg
_____Can't keep warm enough
_____Sweaty palms
_____Blushing, flushing face
_____Coughing
_____Stuffy nose, congestion
_____Earache or ringing noise in ears
_____Common colds
_____Sore throat
_____Asthma or shortness of breath
_____Hay fever or allergies
_____Sore, aching muscles
_____Stiff or tender joints
_____Back problems
_____Trembling/twitching muscles
_____Skin rashes, eruptions
_____Grinding of teeth (TMJ)
_____Dry mouth
_____Mouth sores
_____Excessive perspiration
_____Difficulty sleeping through the night
_____Excessive drowsiness during the day
_____Periods of extreme fatigue
_____Feeling faint or dizzy
_____Feeling tense or nervous
_____Difficulties with family or friends
_____Worrisome thoughts
_____Recurring bad thoughts
_____Thoughts of suicide
_____Fearful of persons or places

_____Feeling inadequate/unable to cope
_____Feeling guilty or failure
_____Uncontrolled crying or sadness
_____Easily annoyed or irritated
_____Free-floating anxiety about life
_____Voice quivering, shaking
_____Eyes irritated or inflamed
_____Vision blurred
_____Eyestrain or discomfort
_____Nosebleeds
_____Stomach cramps
_____Heartburn or indigestion
_____Nausea or vomiting
_____Frequent urination
_____Incomplete urination
_____Painful urination
_____Urinary leakage
_____Bowel leakage
_____Gas in lower bowel
_____Diarrhea
_____Constipation
_____Bowel irregularity
_____Uninterested in sexual relations
_____Unable to participate in sex acts
_____Menstrual difficulties
_____Breast tenderness
_____Hot flashes
_____Water retention
_____Over-eating, bingeing
_____Lack of appetite
_____Excessive alcohol abuse
_____Other substance abuse
_____Frequent laxative use
_____Other:

17. **MEDICATIONS Please indicate below ALL medications which you are currently taking, the problem for which you are using them, the dosages, and their effectiveness**

Medication	For Treatment of	Dose/Amt/Day	Effectiveness

18. Please shade area(s) of pain and/or symptoms.