Kinesiology/ Fascial Stretch Therapy Intake Form

Jeff Conway-Jones, R. Kin, BSFL-ExWell, FST

Patient Name:	**Legal Guardian:**	
Street Address:		
City:	**Postal Code:**	
Phone: (home)	**(Cell)**	**(Work)**
Email Address:		
Occupation:		
Gender *(circle)*: M◯F◯ **(Identify as :_____)**	**Date of Birth:**	
Family Doctor:		
Emergency Contact:	**Relationship:**	
Phone #:		
Who were you referred by?		

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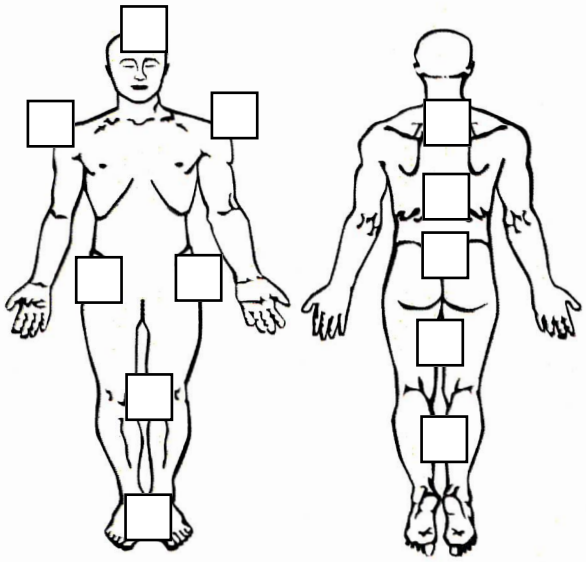
Please list your areas of concern (List in priority sequence).

1. _____
2. _____
3. _____
4. _____

Please circle or mark areas of concern on the diagram.



Have you ever experienced any of the following? Please elaborate.

A hard fall ?

_____

_____

A car accident ?

_____

_____

A concussion ?

_____

_____

A surgery ? what was the procedure ?

_____

_____

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In the past, have you ever experienced pain or injury to :

Hands	☐	Arms	☐	Knees	☐	Mid back	☐
Wrist	☐	Sacroiliac joint	☐	Feet	☐	Upper back	☐
Elbows	☐	Pelvis	☐	Sacrum	☐	Neck	☐
Shoulders	☐	Legs	☐	Low back	☐	Head	☐

Please explain each injury:

_____

_____

_____

_____

_____

_____

Do you wear orthotics?

Yes/ No

◯ ◯

Are you currently taking medications? Please list what/ why.

_____

_____

_____

Do you have any diagnosed medical or psychological conditions ?

_____

_____

Are you pregnant ?

Yes / No / Not Applicable

◯ ◯ ◯

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Are you currently experiencing any of the following symptoms ?

Dizziness	☐	Vertigo Seizures	☐	Speech issues	☐	Difficulty swallowing	☐
Weakness	☐			Trouble with coordination or balance	☐	Pins and needles in any part of your body	☐
Fainting	☐	Disturbance of vision	☐				

Have you noticed any digestive symptoms ? (constipation, diarrhea etc.)

_____

_____

_____

_____

Have you noticed any respiratory symptoms ? (Cough, chest pain, asthma...)

_____

_____

Have you noticed any gynaecological symptoms or disease ? (heavy periods, endometriosis, PCOS...)

_____

_____

Have you ever experienced:

Recurrent ear, throat or sinus infection	☐	Poor appetite	☐
Respiratory disease or disorder (pneumonia, bronchitis...)	☐	Nausea	☐
		Food restriction	☐
Stomach, intestinal or any digestive problem?	☐	Difficulty sleeping	☐
Bladder or kidney infections	☐	Significant weight change in the past year	☐

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Informed Consent Agreement

Treatments may include manual therapies where the health practitioner places his/her hands on patients body. Many techniques will involve contact between the patients body and the practitioners body. Body and hand contact may include areas around the chest wall, pelvic floor, and pubic bones. At times, the practitioner may ask you to remove some items of clothing in order to facilitate proper treatment. If you do not feel comfortable with any part of the treatment, please inform practitioner immediately. The techniques can be discontinued or modified within patients comfort.

Accuracy of Information

I _____ have informed the Practitioner of all my known physical conditions, mental conditions and medications, and I will keep the Practitioner updated on any changes. I understand that the possible risks and benefits of Kinesiology, Fascial Stretch Therapy and Osteopathic Techniques will be explained to me regarding my individual treatment plan and accept responsibility of informing my therapist if I do not understand any aspect of the risks and benefits. I understand that this, and future appointments are not a substitute for medical treatment and/or medications and that it is recommended that I work concurrently with my Primary Caregiver for any conditions I have. I am aware that diagnosing conditions is not part of the Practitioner's scope of practice. I am aware of, and agree to, the fee schedule as presented by Jeff Conway-Jones. All information provided by you is strictly confidential and will not be released without written consent except where required law.

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I authorize Jeffrey Conway-Jones, with my permission, to share any pertinent medical and treatment information with other health care practitioners, **recommended** to me by Jeffrey Conway-Jones, outside or within Back 2 Back inc. in order to provide the best and most holistic treatment possible.

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Agreement to receive treatment

I understand that part of the risk involved in receiving Kinesiology, Fascial Stretch Therapy, and Osteopathic techniques is relative to my own awareness and how I perceive the treatment and will notify the practitioner of any discomfort immediately. I acknowledge that it is my choice to receive any of the aforementioned treatments. I understand that the treatments include, but are not limited to; assisted stretching, soft tissue release and normalizations, muscle energy techniques, fascial stretch therapy, osteoarticular adjustments, active release therapy, joint mobilization, therapeutic application of heat and cold, electric therapy techniques, athletic training and exercise therapy interventions.

Cancellation Policy

Your appointment time is reserved just for you. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee.

I declare that I have read, understood, and agree to the contents of this INFORMED CONSENT AGREEMENT in its entirety.

Signature: _____ Date: _____

* I certify that the above medical information is correct to my knowledge.

Signature: _____ Date: _____

Under 18 consent

Parent or Guardian

I _____ am filling in this form for my child/ dependent. As legal guardian, I am consenting to the above items for this minor to receive treatment from Jeffrey Conway-Jones.