REAL RELIEF
Myofascial Release, LLC

New Patient-Client Information & Medical History

Name:
Occupation (previous, if retired):
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 *Permission to Text? Y N
Email Address: _____ *Permission to email you: Y N

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

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

Signature: _____ Date: _____

==========

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 or Latex allergies:
Height: Weight: Right or Left Handed: R____ L ____

REAL RELIEF
Myofascial Release, LLC

Patient Name: _____

CHIEF COMPLAINT (MAIN reason for today's visit)

Treatment GOALS: (What would you like to be able to do that this issue makes difficult for you?)

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

Body Area:

A-_____ B-_____ C-_____

Pain Scores: (0 to 10)

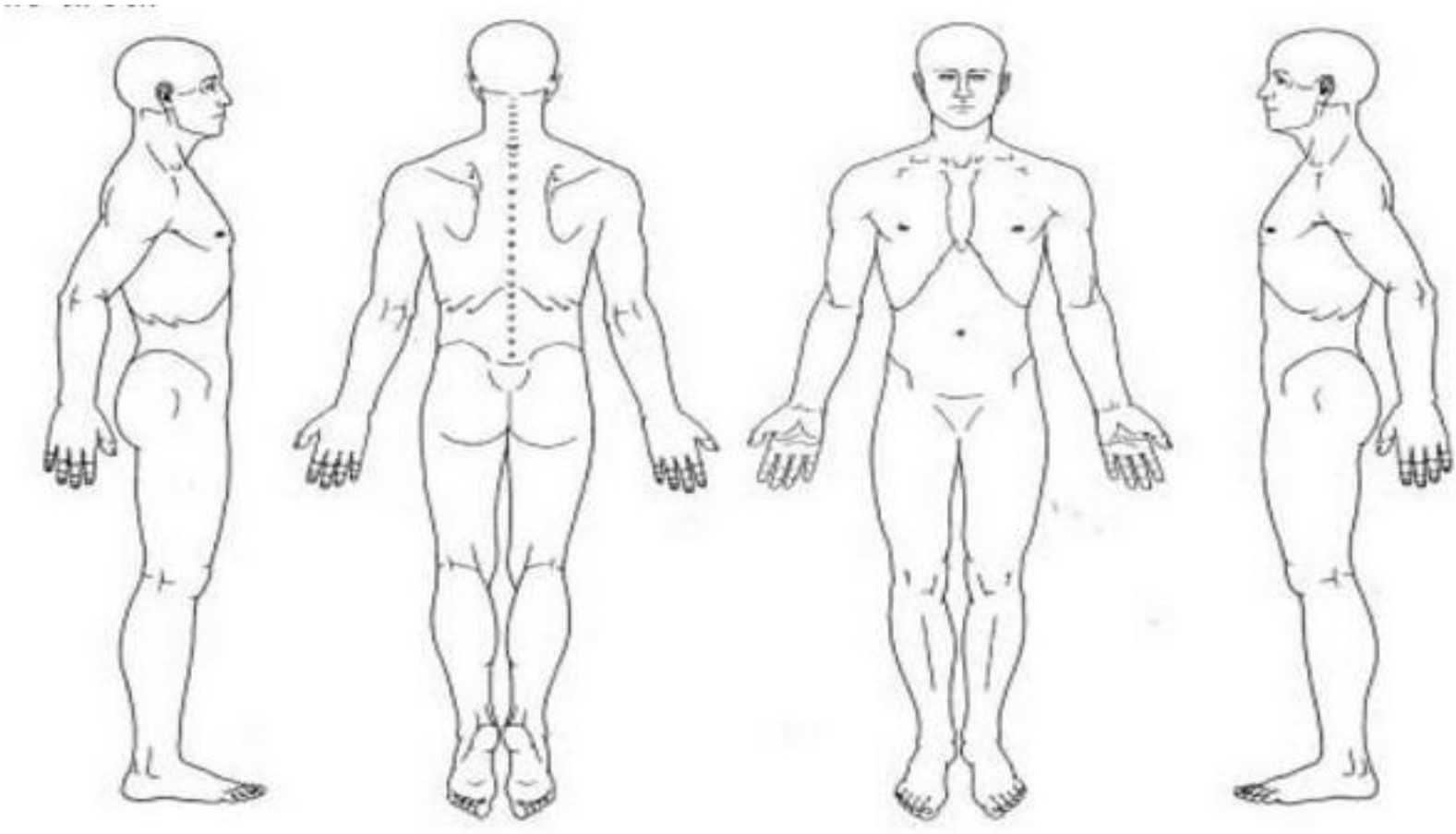
Right Now: A-_____ B-_____ C-_____

At its **worst**: A-___ (% of the day: ___) B-___ (% of the day: ___) C-___ (% of the day: ___)

At its **best**: A-___ (% of the day: ___) B-___ (% of the day: ___) C-___ (% of the day: ___)

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

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



REAL RELIEF
Myofascial Release, LLC

Patient Name: _____

SURGICAL HISTORY, Other PROCEDURES, FRACTURES, Other INJURIES, SCARS

(include "scope" surgeries, cosmetic procedures, implant, mesh, deliveries, other pregnancy-related procedures)

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? Y N
Mental Health:

SOCIAL HISTORY

Occupation/Employment/Daily Activity (current and/or previous):
Hobbies:
Living Situation (marital status, type of housing, people, pets):
Diet:
Sleep: Stressors:
Exercise:
Alcohol: Tobacco: Recreational Drugs:
Religious/ Spiritual:
Victim of Violence/ Sexual Assault:
Military Service:
Other 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?

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 doctor's notes, radiologic reports, 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 before signing, as we continue to discuss my medical history during my treatment session today and in the future.

Patient-Client Signature: _____ Date: _____

Karen F. Harris, MD KarenHarris@RealReliefMFR.com 727-315-0407 www.RealReliefMyofascialRelease.com
14004 Roosevelt Boulevard, Suite 612, Clearwater, Florida 33762

version ABC-IYH 6-23-2026