

Lawrence Gold, clinical somatic education
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Functional Assessment

Text

NAME _____
PHONE (HOME) _____ (WORK) _____

e-mail _____ HOME ADDRESS _____

workshop self-help program, pre-recorded self-help, customized S.I. class=Y

What do you want from our sessions?

Text

Where do you have pain, tingling, numbness, restricted movement? Left = L Right = R

Text

What physical traumas have you suffered in your lifetime (sprains, cuts, broken bones, surgeries, motor vehicle accidents, dental work, episodes of spasms, lifting or overuse injuries)? When? What happened? Where did it hurt? Please include untreated ("not serious") pains and/or injuries, as these may be significant.

What do you do during the day? (e.g., desk work, lifting, walking, athletics, computer, hobbies)

What activities would you like to get back to?

Session notes (practitioner use, only):

Are you currently being treated for any medical problem?
 If yes, elaborate:

n [] y []

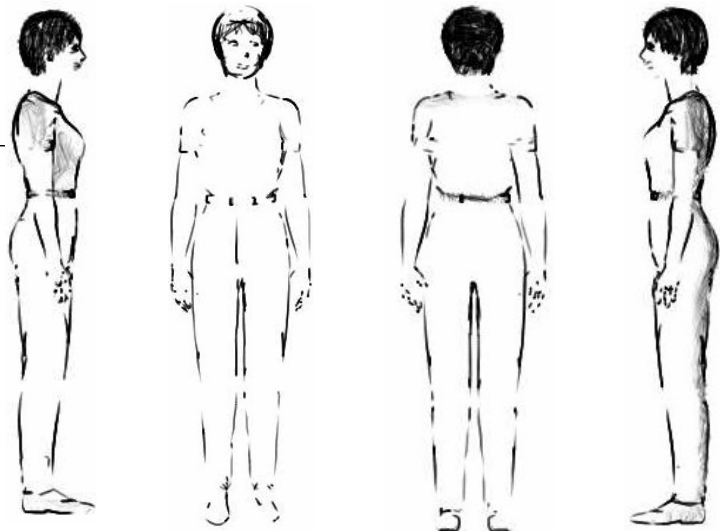
Please mark items that apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> arthritis _____ | <input type="checkbox"/> recent surgery | <input type="checkbox"/> neurological damage |
| <input type="checkbox"/> weakness _____ | <input type="checkbox"/> metal implant | <input type="checkbox"/> breathing difficulty |
| <input type="checkbox"/> stiffness _____ | <input type="checkbox"/> pacemaker | <input type="checkbox"/> poor circulation |
| <input type="checkbox"/> numbness _____ | <input type="checkbox"/> pregnant | <input type="checkbox"/> heart problem |
| <input type="checkbox"/> tingling _____ | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> difficulty urinating |
| <input type="checkbox"/> headaches | <input type="checkbox"/> frequent urination | other _____ |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> degenerating disk(s) | other _____ |

Medications? _____ for _____ what?

What makes you feel worse?

What makes you feel better?



(FOR SIGNATURE)

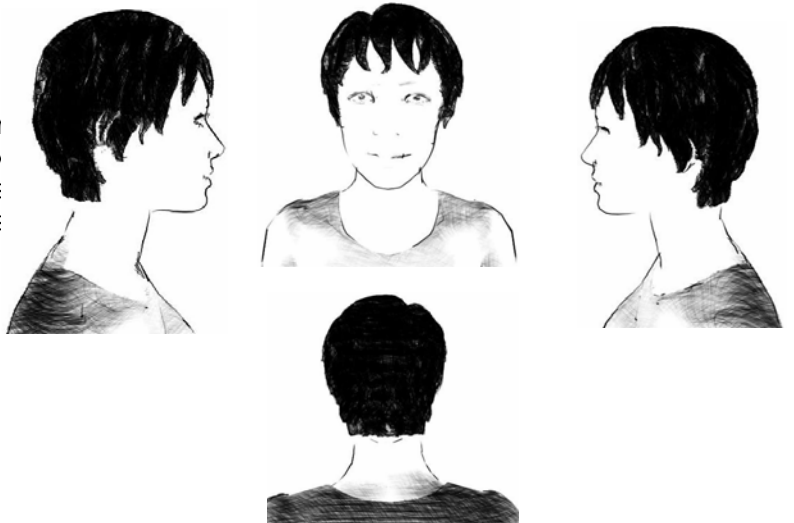
I understand that if I am not satisfied with the results, I may request and receive a refund of fees paid, provided I have completed the [] recommended sessions [____ (initial)] and practiced the recommended somatic exercises.

Except for emergencies, I agree to pay \$35.00 for each appointment missed or cancelled less than 24 hours in advance.

_____ date

(optional) I give permission for Lawrence Gold to photograph my progress and to use such photographs in professional and public communications about Somatics. (specify any limitations)

signature date



PROGRESS REPORT

name _____

Record your condition in one or two sentences.

AFTER **1** **:** **date** _____?

Session **2** **:** **date** _____?
BEFORE _____

AFTER _____

Session **3** **:** **date** _____?
BEFORE _____

AFTER _____

Session **4** **:** **date** _____?
BEFORE _____

AFTER _____

Session 5 : date _____ ?
BEFORE _____

AFTER _____

Session 6 : date _____ ?
BEFORE _____

AFTER _____

Session 7 : date _____ ?
BEFORE _____

AFTER _____

I grant permission for entries marked with an  to be used in public communications about somatic education.

signature _____ date _____