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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? n [ ] y [ ]
If yes, elaborate:

____

Please mark items that apply to you:

[ ] arthritis ____________________
[ ] weakness ____________________
[ ] stiffness ____________________
[ ] numbness____________________
[ ] tingling ____________________
[ ] headaches [ ] frequent urination
[ ] dizziness [ ] degenerating disk(s)

[ ] recent surgery
[ ] metal implant
[ ] pacemaker
[ ] pregnant
[ ] osteoporosis
other ____________________
other ____________________

[ ] neurological damage
[ ] breathing difficulty
[ ] poor circulation
[ ] heart problem
[ ] difficulty urinating

Medications? for what?
____

What makes you feel worse?

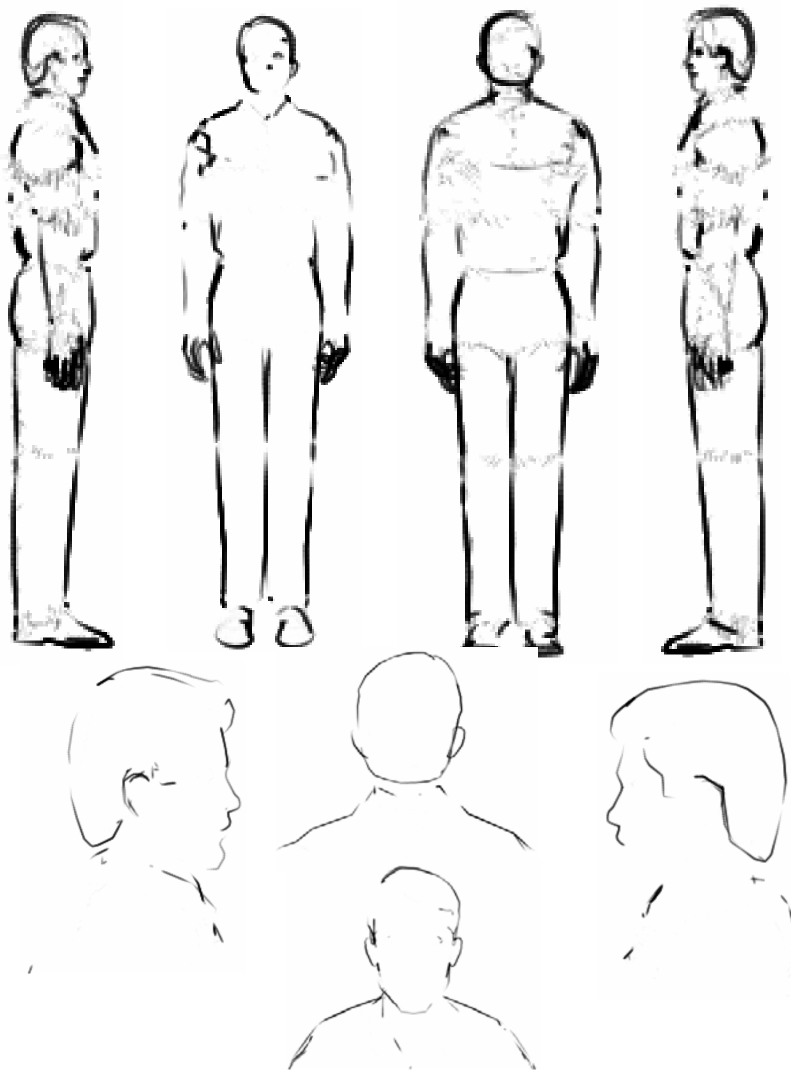
____

____

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 half the fee for each appointment missed or cancelled less than 24 hours in advance. A appointment is considered "missed" 15 minutes after the appointed time.

____________________ __________
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

NOTES BY CLIENT

CONDITION AFTER SESSION

CONDITION AFTER SESSION

CONDITION AFTER SESSION

CONDITION AFTER SESSION

CONDITION AFTER SESSION

CONDITION AFTER SESSION

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