Functional Assessment

NAME _____ _____

HOME ADDRESS _____

PHONE (HOME) _____ (WORK) _____

e-mail _____

[ ] *Somatics* [ ] *Somagic* [ ] *End Your Back Pain* [ ] audio instruction [ ] S.I. [ ] class=Y

What do you want from our sessions?

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

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? Include untreated 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 [ ] neurological damage
[ ] metal implant [ ] breathing difficulty
[ ] pacemaker [ ] poor circulation
[ ] pregnant [ ] heart problem
[ ] osteoporosis [ ] difficulty urinating
other _____
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 and practiced the recommended somatic learning 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