



SFT Comprehensive Patient Questionnaire and Agreement

I understand healing occurs over time and is a process. I acknowledge that I have read Simone's article explaining Fascia and watched the two Fascia videos explaining fascia in detail.

I agree to commit to a minimum of 4 treatments to allow the healing process to begin. I understand that the longer I have had the injury/pain, more treatments may be required to feel pain free. Consistency is the key to healing and improved health. Lifetime of maintenance for example, once a week, once every two weeks or once a month maybe required. Daily stretching and a balanced diet is extremely important to my healing process.

I respect the 24 hour cancellation policy.

Print Name: _____ Signature: _____

Part A: General Information: Date: _____

Last Name: _____ First Name: _____

Age: _____ Birthday: _____

Full Address: _____

Occupation: _____ Email: _____

H: () _____ W: () _____ C: () _____

Emergency Contact: _____ Phone #: () _____

How did you find out about Simone? _____

Were you referred? By whom? _____



Part B – Medical History

List all health professionals you are currently seeing:

Name: Practice: _____

Reason: _____

Name: Practice: _____

Reason: _____

Goals you would like to achieve with Fascia Stretching- for example, better range of motion, reduction of pain, less stiffness, turn head to right or left, and touch toes etc.

Current health conditions you desire improvement in and length of time they have been a concern to you, placed in order of importance:

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

To what extent do these areas interfere with your daily activities (work, sleep, etc.)?

Have you been given a diagnosis for this problem -- if so, what was the diagnosis?



Health History (please circle ones that apply)

Allergies/Hay fever	Alcoholism	Anemia	Arthritis
Asthma	Cancer	Diabetes	Digestive Illness
Epilepsy	Glaucoma	Headaches	Heart Disease
High Cholesterol	Kidney Disease	Mental Illness	Obesity
Stroke	Syphilis		Thyroid Condition
Tuberculosis	Multiple Sclerosis		

Other: _____

Past Medical - please list all surgeries, broken bones, sprains, car accidents etc. Are they relevant to any discomfort you are experiencing today?

Hospitalizations (year, reason):

Surgeries (year, type):

Serious illnesses/injuries/accidents (year, cause/injury):

Childhood illnesses:

Health as a child. 1 = poor to 10 = excellent _____ If less than 8, explain: _____

Rheumatic fever _____ German measles _____ Polio _____ Allergies _____

Chicken pox _____ Frequent colds/flu's _____ Mumps _____ Ear infections _____

Skin conditions (eczema, psoriasis) _____



Allergies: (list all known) Allergy Items Reaction:

Drugs _____

Foods _____

Other _____

Vaccinations: Type, Year, Adverse reactions: _____

Medications: (prescription & over-the-counter) _____

Medication Dose- How Long and For What? _____

Supplements: (non-prescription, herbal, nutritional, any over-the-counter items)

Supplement Dose How long? _____

Have you ever had general anesthetic? Y / N If yes, when? _____

Antibiotic use? Yes / No.

If yes, when? _____

Dental

To the best of your knowledge please list all dental work/treatments you have undergone. Include fillings (specify type), pulled teeth, root canals, bridges, crowns, dentures, braces, retainer/splints, accidents/injuries or any other type of dental/jaw surgery.

Date of Treatment: _____

Describe any current dental concerns or symptoms: _____

Are you aware of any grinding of your teeth or clenching your jaw? Y / N If yes, when? day / night / both



Chemicals

Please list any current or past exposures to solvents, chemicals, cleaning agents, insecticides, herbicides, pesticides, chemical/metal vapors, dry cleaning agents. When? How Long? Work or Home?

Travel (list backcountry & third world trips) Where? When? Illness? or Trauma?: _____

Lifestyle - Enjoy work / retirement? Yes / No. If no, why? _____

What have been your previous occupations? _____

Please indicate on the line below where you feel your current balance between work and play is:

All Work 0 -----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 All Play

Physical Fitness

Exercise regularly? Yes / No. Describe your program: _____

Hobbies - Please list your hobbies or recreational interests: _____

Support, Stressors & Personal Growth

Do you have support for a healthy lifestyle in your household? _____

Do you?: (circle) meditate pray use visualization relaxation techniques

Use other techniques? Yoga, Pilates, Breathing

Describe: _____



How might you finish this statement in regards to suggestions/programs for your health? (Please circle)

I can follow plans / programs I start programs then let things slide

I prefer choosing from options I am easily overwhelmed

How will you know when you are feeling better? _____

How might things look for you when your life is very good and pain free? _____

Do you have any concerns or reservations in pursuing complementary & alternative therapies?

Smoking: (Please circle) How Often? How Long? Quit? If so when? _____

Cigarettes Cigars Pipe Marijuana

Drinking: (Please circle) How often? Daily Weekly How long? Quit?

If so when? _____

Liquor Quantity (Per week) _____

Beer Wine Coffee Soft Drinks

Diet: (for each "yes" list type, serving size & frequency)

Vegetarian? Yes / No If yes, what kind? _____

Meat? Yes / No _____ Dairy? Yes / No _____

Eggs? Yes / No _____ Fruits? Yes / No _____

Vegetables Yes / No _____ Grains / Bread / Pasta / Cereal Yes / No _____



Meal Time Food / Drink

Breakfast _____ Lunch _____ Dinner _____

Snacks / Dessert _____

Cravings? _____ Aversions? _____

What kind of water do you drink and how much? (3 litres or 64 oz a day is recommended)

Any additional information you think would be important to design the perfect health care plan to suit your needs? _____

To contact Simone for an appointment:

Call or text her cellular: 403-422-0881

From the USA: 760-702-1064

Email: simone@simonefortier.com