Aston Patterning® Self-Evaluation Form

Amanda Skidmore
Registered Massage Therapist, Certified Aston Patterning® Practitioner

Date:

Name:

Mailing Address:

Daytime Phone: Cell:

Referred by:

Please note that your session time is reserved for you. If you cannot make it to your reserved time, please inform Amanda 24 hours in advance, so that someone else may receive your time slot. If your session is cancelled less than 24 hours in advance, you will be charged the full fee.

The information you provide will be used to determine your areas of interest and to determine a session sequence tailored to your specific needs, not for purposes of diagnosis.

Please describe your past medical history, with dates whenever possible.

1.Illnesses/Allergies:_____

_____

2. Hospitalizations/Surgeries:_____

_____

3. Accidents/Injuries: _____

_____

4. Current medications: _____

5. What would you like to focus on in your Aston session? (ex: posture, stress relief, athletic performance, injury prevention) _____

6. What is your occupation, and what kind of activities do you perform while working? _____

_____

7. Do any of your occupational activities seem to stress certain areas of your body? Please describe.

_____

_____

8. What kind of leisure activities do you participate in (what, and how frequently)?

_____

9. Have these leisure activities ever caused stress or injury? Please explain. _____

_____

10a. Please describe any specific problems or complaints that led you to Aston-Patterning.

_____

_____

10b. When did you first notice these problems? _____

_____

10c. During what part of the day is this problem less evident? _____

10d. What factors seem to aggravate this problem? _____

_____

10e. What factors seem to ease this problem? _____

_____

10f. Does this problem start in one focused area, and then spread? Please explain.

_____

10g. Are there things that you have stopped doing, or are doing less often because of this problem?

_____

_____

10h. Do you feel that this problem is a result of chronic tension, injury, habit patterns, or any other causes? Please explain. _____

11. What has your physician or other healthcare practitioner provided in terms of diagnosis or treatment?

_____

_____

12. What, if any, other kinds of medical care or body disciplines are you currently involved in, and with whom? _____

_____

13. Is there anything else that you would like your AP practitioner to know about your history, specific problems, or goals? _____

14. I give Amanda Skidmore permission to contact my physician or other health care practitioners (as listed above) to share information about your physical condition. *Please circle one*: Yes No

15. I understand that Aston-Patterning is not a medical procedure and is not a substitute for medical diagnosis (we do not submit our forms and invoices for insurance billing).

Please circle one: Yes No

16. I understand that sessions often include soft tissue work on the whole body, even though my complaint might be in one area, in order to treat not only the symptoms, but the cause of the complaint.

Please circle one: Yes No

Please take a moment to carefully read the following information and sign your name where indicated.

Contraindications for massage:

- Skin diseases, rashes or open wounds
- Malignant tumors
- Inflames blood vessels or greatly swollen joints
- Contagious fevers, flu, T.B., active herpes
- Psychosis or taking strong psychiatric or mild-altering drugs

I have read and understand the specific medical conditions that contraindicate receiving massage therapy. A referral from my primary care provider may be required prior to service being rendered. I understand that the massage/bodywork that I receive is provided for the purpose of stress reduction, relief from muscular tension or spasm, or increasing circulation or energy. If I experience any pain or discomfort during a session, I will immediately inform Amanda so the pressure or strokes can be adjusted to my comfort level. Further, I understand that massage therapists do not diagnose illness, disease, or other physical or mental disorders. Nor do massage therapists prescribe treatment or pharmaceuticals, or perform any spinal manipulations. I affirm that I have stated all my known medical conditions and agree to update Amanda of any changes in my medical profile.

Signature _____

Please print name _____