Trigger Point Myotherapy Patient History

Date of Initial____________________

Name ____________________

Address____________________

Birth Date _____/_____/_____ Age _____ Sex M F

Phone ____________ E-mail ____________

Vocational

Occupation____________________

Still working OR Last worked ____________days/wks/yrs ago

I stopped work because: ____________________

If retired, previous occupation? ____________________

Pain / Injury / Symptoms

Date of *onset* of pain, injury or symptoms _____/_____/_____

If not pain or injury, what are your symptoms? ____________________

____

Describe the event that *started* the symptoms: ____________________

____

Typical pain level varies from: ____________ to ____________

(On a scale of 0-10 with 10 being the worst pain possible)

How long have you had the *pain at the present level?*

_______ Weeks _____Months _____Years

How did the pain start? _____Suddenly _____Gradually

Symptoms are *relieved* by____________________

Symptoms are *increased* by____________________

I have pain (check one or more)

_____Only during activity _____Sometimes at rest

_____ All of the time Pain is present _____% of waking hours

Sleep

_____ Sleep well _____ Frequent difficulty

_____ Occasional difficulty _____ Always have insomnia

I usually wake up feeling _____Refreshed _____ Tired

_____ Stiffer than usual

I usually get: 1-2-3-4-5-6-7-8+ hours of sleep (circle)

Type of mattress _____Firm _____Soft _____Temper Pedic
_____Sleep number _____ Waterbed _____ Other

Type of pillow ____________ Sleep position ____________

Reviewed by ____________________LMT/ CMTPT

Diagnostic Tests (indicate part of body and date)

X -rays ____________ MRI ____________

EMG ____________ CAT Scan ____________

Bone Scan ____________ Blood Tests ____________

Other ____________________

Medications (List all)

____
____
____
____
____

Previous Treatment For Pain - I have seen the following doctors or healthcare providers concerning this pain - injury - symptom:____________________

____
____
____

Medical Conditions

- Heart
- Lungs
- Liver
- Kidney
- Digestive System
- Infection
- High Blood Pressure
- Thyroid
- Cancer
- Other - list below

____
____
____

Medical Procedures (include surgeries, chiropractic, therapies)

Procedure	Date	Procedure	Date

Significant Trauma/Accidents (include incidents that happened at *any time* in your life)

Type of accident/Injury - Body part affected	Date

Any other information you feel may be helpful in your treatment____________________

____
____
____
____

Exercise Habits

Frequency	# of times and hours/week	Type of activity
o Regular		
o Occasional		
o Never		

Hobbies and Other Interests

____
____
____
____

Diet (be honest - there are no wrong answers)

Typical Breakfast
____
____

Typical Lunch______________________________
____

Typical Dinner______________________________
____

Foods Regularly Eaten (check applicable boxes and *indicate how often)*

o Red Meat	o Chicken/Turkey
o Fish	o Bread/Grains
o Fruit	o Vegetables
o Dairy/Yogurt/Cheese	o Water
o Milk	o Coffee
o Pop	o Sweets

I Snack On ______________________________

I Crave ______________________________

I Avoid ______________________________

Vitamins/Mineral/Supplements - List and indicate how often______________________________
____
____
____
____
____

Personal

_____Right Handed _____Left Handed _____Use Both

Smoke? _____ NO _____YES # Packs/day/week _______

Alcohol? _____NO _____YES # Drinks/day/week _______

Current Social/Living Arrangement: _____Married _____ Single _____Separated _____Divorced _____Other______________

Does your pain/injury affect your sexual activity? ___No ___ Yes

Personal Continued

I live with (check all that apply)

_____Spouse/Partner _____Friend _____Children ____Family Member _____Alone _____ Pets

Most of the time I feel (check one for each line)

o Happy	o Neutral	o Sad
o Relaxed	o Neutral	o Anxious
o Satisfied	o Neutral	o Worried
o Enthusiastic	o Neutral	o Depressed

Disability / Benefits

Check all that apply

- o Receiving Workers Comp
- o I have applied for benefits
- o I have lawsuit pending
- o Settlement or other benefits
- o No benefits pending
- o Other - please explain______________________________
____

What are you unable to do because of your symptoms that you want to do?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Therapists Comments

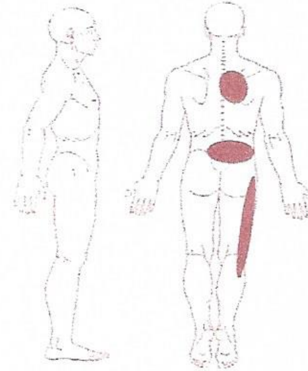
____

Inner Balance Myotherapy

Pain Chart

Name________________________________ Date____________________________

Instructions :Complete "Pain Chart" by filling in any areas on the body below where you have any pain, tightness, numbness or tingling.



Comments____

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