Myofascial Trigger Point Therapy
Patient History

Please complete this form before your Initial Myofascial Trigger Point Therapy Evaluation and bring it with you to your appointment. Thank you.

Patient Name: _____ **Date of Birth:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____

Email: _____ **Referred by:** _____

Emergency Contact Name: _____ **Number**: _____

Have you had a professional massage before? _____

If yes, how often do you receive massage therapy?_____

Do you have any difficulty lying on your front, back, or side? _____

If yes, please explain_____

Do you have any allergies to oils, lotions, or ointments? _____

If yes, please explain _____

Medical History

How long have you had Chronic Muscular Pain?

_____

When did you notice the symptoms?

_____

Was there an event or illness that started the pain? _____

_____

Are you currently under medical supervision? _____

If yes, please explain _____

_____

Please circle other therapists you are currently seeing or have seen in the past:

Chiropractic Physical Acupuncture Massage Other:_____

What medications you are currently taking? _____

_____

What medications have you tried in the past and why did you stop taking them? _____

How much water do you drink a day?

_____

Please list any vitamins, minerals, and supplements you are currently taking:

1. _____
2. _____
3. _____

Please list any accidents or surgeries you have undergone, starting with the most recent:

Date of accident/surgery	**Accident/Surgery**
_____	_____
_____	_____
_____	_____

Do you currently wear shoe orthotics? _____

If yes, how long have you been wearing them? _____

Do you now, or did you as a child, prefer to sit on one leg? _____

Do you have any food sensitivities? _____

If yes, please list: _____

Do you have any other medical conditions?

_____

_____

_____

Personal Wellness

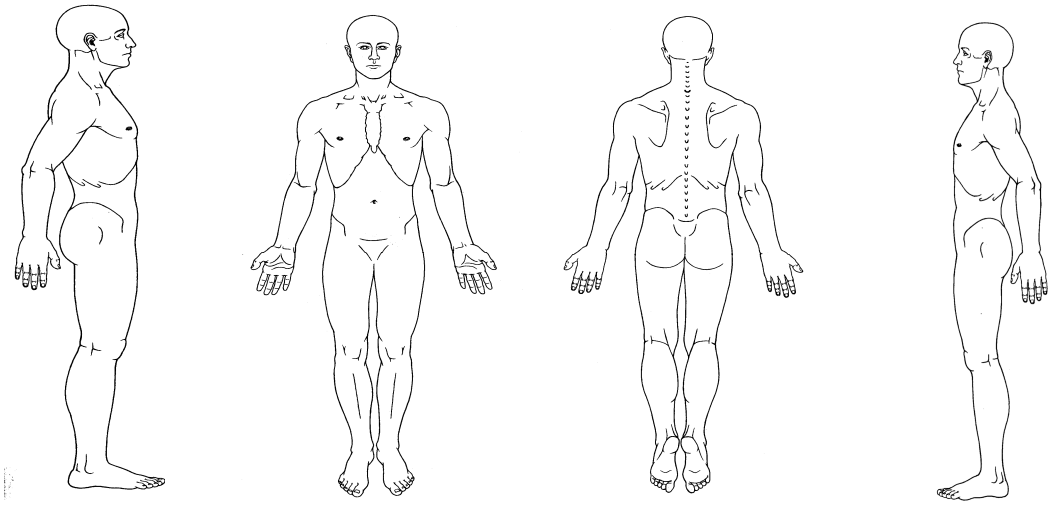
What are your goals to improve the quality of your life?

1. _____
2. _____
3. _____

Patterns/Body Chart

Refer to the body chart below. Shade in the area(s) where you are experiencing pain. You can draw lines to indicate specific regions, or add any descriptive words to specify what you are feeling in that region, e.g., burning, sharp, shooting, dull, aching, numbness, tingling.

Right Side **R** **L** **L** **R** **Left Side**



Does anything increase your pain? If yes, please explain. _____

_____

Does anything relieve your pain, e.g., medication, heat, cold?_____

_____

Is the pain associated with any movements you make? _____

Do you experience any pain in the morning? If so, please describe. _____

_____

Does the level of pain increase, decrease, or stay the same in the evening before bed?

_____

Does your pain change with the weather? _____

Work Stress

Are you able to work? _____

If yes, what is your occupation?

_____

Is your pain affecting you at work? If so, please describe.

_____

_____

Do you perform repetitive movement at work? _____

Are you immobile for long periods? _____

Home Stress

Do you have childcare or home-tasks? _____

Are you immobile for long periods? _____

Do you read while laying on a couch/bed? _____

Exercise/Stress

Do you participate in sports or do you workout? _____

_____

Are you aware of any old injuries (accidents, youth, high school, college, etc. sports)?

_____

_____

How stressed are you from day to day (please circle)?

High High-Medium Medium Medium-Low Low

Sleep

What position do you most often sleep in? (circle)

Back Side Stomach Arms Overhead

Half-stomach/half side Fetal position Pets in bed Spooning with partner

Do you use any pillows between the legs? _____

Do you use any pillows at the chest? _____

How often do you sleep in each position? _____

Are there any reasons you sleep in these positions? _____

How many hours of sleep do you typically get? _____

Do you have difficulty falling asleep? _____

Do you wake up often in the middle of your sleep? _____

Jaw/Facial/Head Pain

Do you have TMJ? _____

Do you have jaw pain associated with chewing or yawning? _____

Do you clench or grind your teeth? _____

Do you wear a night guard or mouth splint? _____

Do you get headaches? _____

Do you experience dizziness? _____

Do you have difficult or painful swallowing? _____

I, _____ (print name) understand that the treatments I receive should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that trigger point therapists are not qualified to perform spinal or skeletal adjustments, prescribe, or treat any physical or mental illness, and nothing said in the course of the session should be construed as such. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that trigger point therapy should not be performed under certain medical conditions. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Client _____ Date _____

Thank you for taking the time to complete this form.
I look forward to working with you on your journey to pain free living!

Yoga on 45th - FSM Microcurrent

Is it possible you are pregnant?

Y_____ N_____ N/A_____

Do you have a pacemaker, heart device or any kind of implanted stimulator or pump?

Y_____ N_____

How many caffeinated beverages have you had today?

_____

How much water have you had today?

_____

Do you have an active infection?

_____

Are you on antibiotics?

_____

I, _____(print name) understand that the treatments I receive should not be construed as a substitute for medical examination, diagnosis, or treatment. I agree to the use of mircocurrent therapy and understand that there are no known risks involved. I will inform my therapist of any discomfort I may experience and have answered all questions honestly and will inform my therapist of any changes in health conditions prior to any microcurrent treatments that I receive.

Sign: _____ Date:_____

Yoga on 45th - Trigger Point Therapy

We understand that sometimes things come up that prevent you from making your scheduled appointment. In that case, please be sure to cancel your appointment at least 24 hours ahead of time. We set aside valuable time just for you and may have a wait list for that particular time of day.
This helps us care for everyone who needs to be seen. In the event of a late cancellation (less than 24 hours) or a no show, we will charge your credit card for the full cost of the missed appointment. If you arrive late, we will do our best to try to accommodate you, but in the event that the session is cut short, you will be responsible for the full session amount. Thank you for your understanding.

Name:_____

Billing Street Address:_____

City:_____ State:_____ Postal code:_____

Direct Telephone:___(_____)_____-_____

_____**(Initials)** I authorize a late-cancellation, in the event that I cancel with less than 24-hr notice, against my credit card and I authorize my credit card information to be saved in the charge system.

_____**(Initials)** I authorize a no-show charge, in the event that I do not appear for my scheduled appointment, against my credit card for the full cost of the session and I authorize my credit card information to be saved in the charge system.

If you need to cancel or reschedule an appointment, please call or text 219-218-2378, a minimum of 24-hours prior to your appointment time.