WEST SUBURBAN PAIN RELIEF

The Trigger Point Experts

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** : _____

Address : _____ **Birthdate** : _____
: _____ **Phone** : _____
: _____ **Email** : _____
Employer : _____ **SSN** : _____

Medical History

How long have you experiencing the condition you are seeking treatment for?

_____

Was there an event or illness that triggered it?

_____

Please list any injuries, accidents (e.g. car, bicycle, fall) or surgeries you have undergone, starting with the most recent and going back as far as you can remember. EVERYTHING matters, so please try to answer as completely and thoroughly as possible.

Approximate Date	**Description of Injuries/Accident/Surgery**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Height _____ Weight _____

Have you been told by a physician that you have the following:

Herniated or Bulging Disks	Yes / No	Osteoporosis/Osteopenia	Yes / No
Spinal Stenosis	Yes / No	Arthritis	Yes / No
Scoliosis	Yes / No	Hypermobility Disorders	Yes / No
Fibromyalgia	Yes / No	Heart Disease	Yes / No
Carpal Tunnel Syndrome	Yes / No	High Blood Pressure	Yes / No
Diabetes	Yes / No	Kidney Disease	Yes / No
Thyroid problems	Yes / No	Stroke	Yes / No
Auto-immune disorders	Yes / No	Circulatory Problems	Yes / No

Please list any specific diagnosis related to your condition? _____
Do you have imaging/test results related to your condition? _____
Have you been or are you currently going through menopause? _____

Are you ___ right-handed or ___ left handed?

Do you wear shoe orthotics? Yes / No. If yes, how long? _____

Do you now, or did you as a child, prefer to sit on one leg? Yes / No

Do you have any food sensitivities? Yes / No. If yes, please list:
_____

List any medications you are currently taking:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List any supplements or vitamins you are currently taking:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List any medications you have tried in the past and the reason you stopped taking it:
1. _____
2. _____

Please circle other current or past therapists/therapies you have tried:

Chiropractic	PT	Tens Unit	Ultrasound	Cortisone Injections
Acupuncture	Massage	Asian Bodywork	Other: _____	

Work Stress

Do you work outside of home/childcare? Yes / No

If yes, what is your occupation?

_____

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

_____

_____

Do you perform repetitive movement at work? Yes / No

Are you immobile for long periods at work? Yes / No

How do you feel after a day of work?

_____

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?

_____

At certain times of the month/week does your pain change? If so, how?

_____

Does your pain change with the weather?

_____

What are your goals for treatment with us?

1. _____
2. _____
3. _____

Jaw/Facial Pain

Do you have TMJ? Yes/No
Do you have jaw pain associated with chewing or yawning? Yes/No
Do you clench or grind your teeth? Yes/No
Do you wear a night guard or mouth splint? Yes/No
When was your last dental appointment? _____
When was your last eye exam? _____
Do you wear bifocals/trifocals? _____

Home Stress

Do you have childcare or home-tasks? Yes / No
Are you immobile for long periods at home? Yes / No
Do you read while laying on a couch/bed (neck flexed forward)? Yes / No

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

If you sleep on your back:
Do you use pillows under the knees? Yes / No

If you sleep on your side:
Do you use any pillows between the legs? Yes / No
Do you use any pillows at the chest? Yes / No

Are there any reasons you sleep in these positions? _____

How many hours of sleep do you typically get? _____

Do you have difficulty falling asleep?	Yes/no
Do you wake up often in the middle of your sleep?	Yes/no
Do you wake up feeling tired?	Yes/no
Have you ever had a sleep study?	Yes/no
If yes, were diagnosed with Sleep Apnea	Yes/no
Have you been advised to use a CPAP machine?	Yes/no

Exercise

Are you able to exercise? Yes / No
If yes, what type of exercises do you do and how frequently? Please be specific.

_____

_____

If not, what are your reasons for not exercising?

_____

What kind of exercises do you think you would enjoy doing?

_____

Smoking/Alcohol/Caffeine/Sugar

Do you smoke or use tobacco products? Yes / No

If yes, what kind and how much per day?

_____

Do you drink alcohol? Yes / No

If yes, what kind and how often?

_____

Do you drink caffeinated beverages? Yes / No

If yes, what kind and how often?

_____

Do you drink juice? Yes/No

If yes, what kind and how often?

_____

How much water do you drink a day?

_____

Thank you for taking the time to complete this form.
We look forward to working with you on your journey toward better health!

Please bring any test results/films/reports that may be relevant to your condition.