



# 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.**

<b>Name</b>	: _____	<b>Date</b>	: _____
<b>Address</b>	: _____	<b>Birthdate</b>	: _____
	: _____	<b>Phone</b>	: _____
	: _____	<b>Email</b>	: _____
<b>Employer</b>	: _____	<b>SSN</b>	: _____

**Chief Complaint:**

\_\_\_\_\_

**Medical History**

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

Please list any specific diagnosis related to your current condition? \_\_\_\_\_

Do you have imaging/test results related to your condition? \_\_\_\_\_

Was there an event or illness that triggered it? \_\_\_\_\_

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

Please list all injuries, accidents, or surgeries, starting with the most recent and going back as far as you can remember. **EVERYTHING** matters, so please try to answer as thoroughly as possible.

**Approximate Date**

**Description of Injuries/Accident/Surgery**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Have you **ever** been diagnosed with or treated for any the following conditions (circle if yes):

Herniated or Bulging Disks	Yes / No	Diabetes	Yes / No
Spinal Stenosis	Yes / No	Thyroid problems	Yes / No
Scoliosis	Yes / No	Auto-immune disorders	Yes / No
Other Spinal Injury or Disorder	Yes / No	Pelvic Floor Dysfunction	Yes / No
Fibromyalgia	Yes / No	Osteoporosis/Osteopenia	Yes / No
Carpal Tunnel Syndrome	Yes / No	Osteoarthritis	Yes / No
Thoracic Outlet Syndrome	Yes / No	Rheumatoid Arthritis	Yes / No
Rotator Cuff Injury	Yes / No	Hypermobility Disorders	Yes / No
Fracture of any Type	Yes / No	Heart Disease	Yes / No
Tear of any Ligament	Yes / No	High Blood Pressure	Yes / No
Tendinitis/Tendinosis/Tendinopathy	Yes / No	Kidney Disease	Yes / No
Whiplash	Yes / No	Stroke	Yes / No
Traumatic Brain Injury/Concussion	Yes / No	Circulatory Problems	Yes / No
IBS/Crohn's Disease/Colitis	Yes / No	Menopause	Yes / No
TMJ/Jaw joint disorder?	Yes / No	Pain with chewing/yawning?	Yes / No
Do you clench or grind your teeth?	Yes / No	Do you wear shoe orthotics?	Yes / No
Use a night guard or mouth splint?	Yes / No	Are you pregnant?	Yes / No
Bifocals/trifocals/progressive lenses?	Yes / No	Do you wear contact lenses?	Yes / No

Do you have primary care physician? Last Visit? \_\_\_\_\_

Have you seen a specialist for this condition? Last Visit? \_\_\_\_\_

When was your last dental appointment? \_\_\_\_\_

When was your last eye exam? \_\_\_\_\_

Are you \_\_\_ right-handed or \_\_\_ left handed?

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. \_\_\_\_\_
3. \_\_\_\_\_

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

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

Do you feel that you eat a balanced diet? **No / Yes:** Describe \_\_\_\_\_

Do you smoke or use tobacco products? **No / Yes:** What kind and how much/often? \_\_\_\_\_

Do you drink alcohol? **No / Yes:** What kind and how much/often? \_\_\_\_\_

Do you drink caffeinated beverages? **No / Yes:** What kind and how much/often? \_\_\_\_\_

How much water do you drink a day? \_\_\_\_\_

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

\_\_\_\_\_

Do you have any allergies? Yes / No. If yes, please list:

\_\_\_\_\_

What are your goals for treatment with us?

\_\_\_\_\_

### **Work**

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

Do you perform repetitive movement at work? Yes / No

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

Occupation: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

### **Home**

Do you have childcare, eldercare responsibilities? Yes / No

Do you have regular household responsibilities? Yes / No

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

Do you sit in on a couch, a recliner or in a chair most often at home? \_\_\_\_\_

Do you read while laying on a couch/bed (neck flexed forward)? Yes / No

How stressed are you overall 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?

\_\_\_\_\_

## Childhood

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

As far as you know, did you experience normal development as an infant/young child? Yes / No

Were you treated for any developmental delays? \_\_\_\_\_

Did you play competitive sports as a child? \_\_\_\_\_

Were you unusually flexible as a child? \_\_\_\_\_

Did you receive a full range of childhood vaccinations? \_\_\_\_\_

If you are comfortable answering, did you experience trauma as a child? \_\_\_\_\_