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.

Name : _____ **Date** : _____

Address : _____ **Birthdate** : _____
: _____ **Phone** : _____
: _____ **Email** : _____

Have you/anyone in your household traveled outside the US in 2020? If yes, where?_____
Have you/anyone in your household flown in the last 30 days? If yes, where?_____
Have you/anyone in your household experienced a cough/fever recently?_____

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 that you can think of

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? _____