Myofascial Trigger Point Therapy

Patient Medical History Form

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: _____ **DOB**: _____

Phone: _____ **Email**: _____

Emergency Contact and Phone: _____

Where did you hear about The Tomo Touch? _____

Medical History

How long have you had Chronic Muscular Pain (and/or Fibromyalgia)?

_____

When did you notice the symptoms?

_____

Was there an event or illness that started the pain?

_____

Please list any accidents (e.g. car, bicycle) or surgeries you have undergone, starting with the most recent:

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

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

Herniated or Bulging Disks Yes / No

Diabetes Yes / No

Spinal Stenosis Yes / No

Scoliosis Yes / No

Thyroid problems Yes / No

Do you currently wear shoe orthotics? Yes / No

If yes, how long have you been wearing them?

_____

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:

_____

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

Chiropractic Physical Therapy Acupuncture Massage Other: _____

List any medications you are currently taking:

1. _____

2. _____

3. _____

4. _____

List any medications you have tried in the past and the reason you stopped taking it:

1._____

2._____

3._____

4._____

Personal Wellness

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

1. _____

2. _____

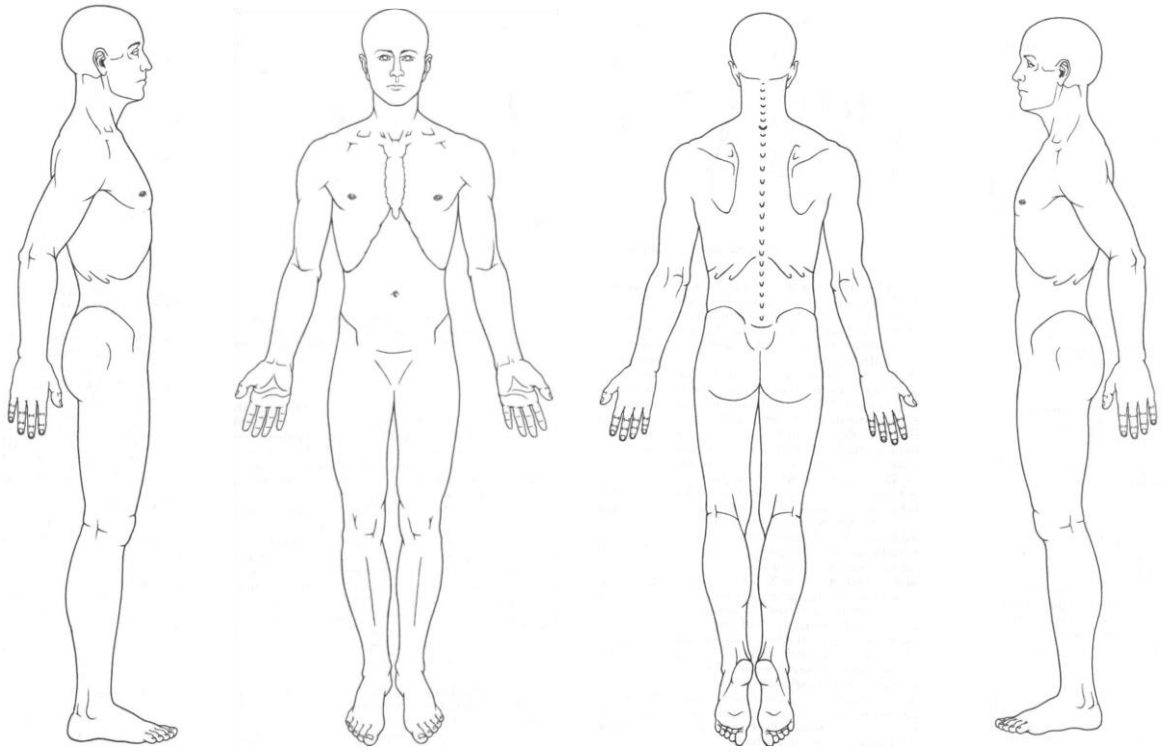
3. _____

4. _____

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?

_____

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

_____

Does your pain change with the weather?

_____

Work Stress

Are you able to work? 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? Yes / No

How do you feel after a day of work?

_____

Home Stress

Do you have childcare or home-tasks? Yes / No

Are you immobile for long periods? Yes / No

Do you read while laying on a couch/bed? Yes / No

Exercise/Stress

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?

_____

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

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? Yes / No

Do you wake up often in the middle of your sleep? Yes/no

Do you wake up feeling tired? Yes / No

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?

_____

Do you frequently eat food with high amounts of sugar/carbohydrates? Yes / No

If yes, what kind and how often?

_____

Water/Supplements

How much water do you drink a day?

_____

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

1. _____
2. _____
3. _____

Jaw/Facial Pain

Do you have TMJ Disorder? 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 bifocals/trifocals? _____

Do you wear a night guard or mouth splint? Yes/No

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