



**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: _____

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 Tens Unit
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. _____

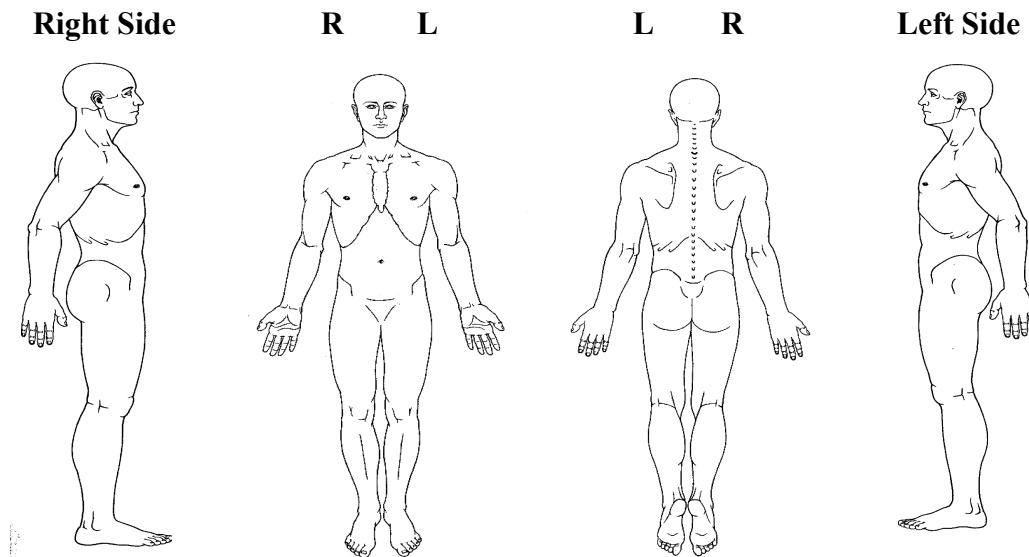
Personal Wellness

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.



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 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? Yes/No

Do you have jaw pain associated with chewing or yawning? Yes/No

Do you clench or grind your teeth? Yes/No

When was your last dental appointment? _____

When was your last eye exam? _____

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.
We look forward to working with you on your journey toward better health!**