BODY & SPINE
SOLUTIONS

MYOFASCIAL TRIGGER POINT THERAPY PATIENT 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: _____ City: _____ State: _____ Zip Code: _____

Telephone #: _____ Date of Birth: _____

PAIN HISTORY

How long have you had chronic muscular pain, joint pain and/or fibromyalgia? _____

When did you notice the symptoms? _____

Was there an event, illness or incident that started the pain? _____

_____

Have you ever been told by a physician that you have any of the following?

Herniated or Bulging disks? YES NO

Diabetes? YES NO

Spinal Stenosis? YES NO

Scoliosis? YES NO

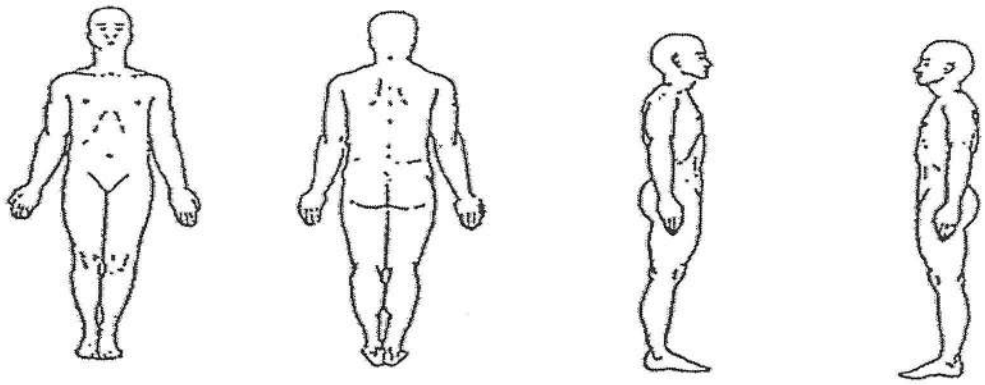
Thyroid Problems? YES NO

List any medications you are currently taking:

1) _____ 2) _____

3) _____ 4) _____

Refer to the body chart below and 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.



How Stressed are you from day to day (please circle)?

High High-Medium Medium Medium-Low Low

What position do you mostly sleep in?

Back Side Stomach Arms Overhead Half-Stomach/Half Side

Fetal Position Pets in Bed Spooning with Partner

Insurance Information

Name of Insurance Company:_____

Insurance ID:_____

Name of Insured:_____

I certify that the information given is correct to the best of my knowledge. I will not hold my doctor or staff responsible for any errors or omissions I may have made in the completion of this form

Signature of Patient: _____

Date: _____