

MYOFASCIAL TRIGGER POINT INTAKE FORM

ALL ACCIDENTS AND DATES

EXERCISE

I get exercise by: (how often) _____

Are you active now? Doing what? _____

DIET

Typical breakfast: _____

Typical lunch: _____

Typical dinner: _____

I often eat: _____

Red meat ___ Chicken ___ Fish ___

Bread ___ Yogurt ___ Cereals ___ Cheese ___

What vegetables? _____

What fruit? _____

How much milk per day? _____

How many cups of coffee daily? _____

How many glasses/cans of other drinks _____

I snack on: _____

I crave: _____

I avoid: _____

How many glasses of water daily? _____

Vitamins/minerals? Yes ___ No ___

Which ones? _____

PERSONAL

(Circle) Right-Handed or Left-Handed

Smoke? No ___ Yes ___ Packs a day ___

Alcohol? No ___ Yes ___ Drinks per week ___

I am: Married ___ Single ___ Separated ___

Widowed ___ Divorced ___

Sexually Active? Yes ___ No ___ Problems? ___

Spouse/Partner name: _____

I live with: spouse/partner ___ children ___

Friend ___ family member ___ alone ___ pets ___

I am satisfied with this arrangement? _____

Most of the time lately I feel

(CHECK ONE WORD IN EACH LINE)

happy ___ neutral ___ sad ___

relaxed ___ neutral ___ anxious ___

satisfied ___ neutral ___ worried ___

enthusiastic ___ neutral ___ depressed ___

DISABILITY BENEFITS

___ Receive workers compensation for ___

___ Have applied for (increased) benefits

___ no application pending

___ have lawsuit pending (auto)

What are you unable to do because of pain
that you want to do? _____

THERAPIST'S COMMENTS

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IDENTIFICATION

Name _____
SSN _____ Sex _____
Birthday _____ Age _____

VOCATIONAL

Occupation _____
I am still working _____, or I last worked:
_____ weeks _____ months _____ years ago
I stopped work because: _____

PAIN

Date of injury _____

Check pain in the following areas:

Right	Left	
_____	_____	Headache & eye
_____	_____	Jaw pain
_____	_____	Neck pain
_____	_____	Shoulder pain
_____	_____	Arms/forearms/hands
_____	_____	Chest
_____	_____	Abdomen
_____	_____	Upper back
_____	_____	Mid and low back
_____	_____	Hips/buttocks/groin
_____	_____	Legs and feet

*Please PUT A STAR in front of worst pain

When did your pain first start?
_____ weeks _____ months _____ years ago

How did the pain start?
_____ suddenly _____ gradually

Describe the event that started the pain: _____

How long have you had the pain at the present severity? _____ weeks
_____ months _____ years

Pain is present: (mark one)
_____ only during activity
_____ sometimes at rest
_____ all of the time

What do you think causes your pain? _____

My typical pain level is _____
(0-10 with 10 worst pain possible)
Pain is increased by: _____
I get relief by: _____
I have pain _____ % of my waking hours.

TESTS

Date & result? (Circle) X-Rays _____
EMG _____ MRI _____ CAT Scan _____
Bone Scan _____ Blood Tests _____

MEDICATIONS

List ALL the medications you take or use regularly or occasionally, include home remedies:

PREVIOUS TREATMENT FOR PAIN

I have seen the following kind of specialists and health care providers concerning this pain problem (include approximately when and results)

SLEEP

_____ I sleep well, no trouble
_____ I have occasional difficulty
_____ I have frequent difficulty
_____ I always have insomnia
I usually wake up feeling:
_____ refreshed _____ better _____ as tired
_____ I usually get _____ hours of sleep
When I get up in the morning, my muscles:
_____ are stiffer than usual
_____ are stiff and take _____ hours to loosen up
What kind of mattress? _____ Waterbed? _____
What kind of pillow _____

SLEEP POSITION? _____

OTHER MEDICAL CONDITIONS

MEDICAL PROCEDURES/DATES

