Triangle Trigger Point Therapy

Confidential Case History for Triangle Trigger-Point Therapy (Please print clearly). **Note**: Contraindications for receiving neuromuscular therapy may be acute trauma, broken bones, illnesses, severe colds or infections, active cases of shingles, GBS, epilepsy, etc. If any of the above apply, let us know.

About you/your pain:

Name: _____ Date: _____

Home Phone (_____) _____Work Phone (_____) _____
(Include Area Code)

Cell Phone (_____) _____E-Mail_____

Of the above contact information, what is the quickest way to reach you during

the day?_____After 5?_____

Where would you like reminder calls?_____

Whom may we thank for referring you?_____

If you did not come from a referral how did you hear about us?_____

Will you need CPT coded receipts?

Home address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Place of employment: _____

DOB _____ Age_____ Single _____ Married _____ divorced_____

Spouse's name and contact information
_____

Ages of children _____

Height_____Weight: _____Blood Type_____Are you allergic to

latex?_____Any other allergies?_____

Who is your Primary Care Physician?

_____

Surgeon_____P.T_____

OBGYN_____Dentist_____

Orthodontist_____Chiropractor_____

Acupuncturist_____Other?_____

Please describe in detail why you are here? Using words like burning, radiating, stabbing, aching, throbbing, numb, tingly, itchy, shooting, restless, cramping, etc., and where it is located.

_____

_____

_____

Have you seen any of the above health care providers for this condition, and if so, who?

What did they say about it?_____

Were there diagnostic tests performed and what was found? _____

_____

How long has this pain been bothering you?_____

Is this first time you have ever had it? _____If not, when was the first

time?_____

On a scale of 1-10 (10 high) how much pain are you in today? ____ What do you think caused it?_____

Are there any other areas of your body that hurt or give you trouble and if yes,

please describe?_____

_____

If the pain you are here for today is not present at all times, is there anything that you do which will quickly bring on quickly, or make it worse? Please describe

_____

_____

Does this pain interrupt your sleep? Y or N How often? _____

What have you tried prior to coming here to get relief from any of the aches and pains that you have listed so far? Circle all that apply:

Over the counter medications
Prescription medications
Weight loss
Stretching
Cardio vascular exercise
Weight lifting
Chiropractic
Massage or bodywork
Changing pillows or mattress
Heel lifts or shoe builds
Back supports or leg braces
Electric devices
Medication injections
Yoga, Pilates, etc.
Acupuncture
Osteopathic treatments
Taking time off work/resting
Sleeping
Taking a walk/moving around
Taking a hot showers
Taking a hot bath or hot tub
Ice packs or ice dips
Heating pads
A new chair, couch, car, etc.
Arch supports/shoe lift/etc.
Surgery, lasers, etc.
Topical creams or gels
Physical therapy
Crying, screaming, praying
Mouth guard/splint/braces
Anything not listed here _____

Of these, what has been most helpful?_____

What is the longest amount of time that you have been able to get relief using the above treatment(s)? _____

Is there anything that you have had to give up because of the pain you are here for that you would like to resume doing in the future? _____

_____

Do you have other fitness goals we can assist you with once pain is better?

_____

_____

Health/History:

When was your last complete physical including blood work?_____

Have you ever had a stress test/cardio-vascular fitness

test?_____When?_____Lung/chest x-ray?_____

When?_____Complete spinal x-ray?_____When?_____

MRI_____When?_____CAT scan?_____When?_____

Arthrogram?_____When?_____Other?_____

Do you have high or low blood pressure?_____Arthritis?_____

Fibromyalgia?_____Other diagnosed health conditions? List:

_____

Even if you do not think it was a big deal, have you ever been in an impact accident such as car, boat, motorcycle, etc? And if yes, how many times, how old were you and how fast were you (and the other object if you hit something else) going?_____

_____

_____

_____

Have you ever had a bad fall or sporting injury that caused soreness/pain for more than 2 days, visible bruising, concussion, etc. (i.e. from a crib, off a bed, a porch, out of a tree, off a house, off a bike, a skateboard, on ice, etc.) and how many and how old were you?

_____

_____

In any of the above accidents what was injured?_____

Did you have residual or recurring pain in any of these areas days, weeks or months afterward or as the years passed?_____Describe_____

_____

Have you ever broken any bones, sprained, strained or torn a muscle, tendon or ligament? And if so how old you were you and describe what happened _____

_____

_____

Have you ever had a surgical procedure? Necessary or cosmetic. List the year,

your age and what was done_____

_____

Complications?_____

Has anyone ever told you that you have a leg length

difference?_____Who?_____When?_____

Short R or L and by how much_____Were x-rays of your pelvis and

legs taken to determine this?_____If not, how was it measured?_____

_____

Do you currently have a full build on the short leg side, wear inserts, arch supports, orthodics or heel lifts?_____How often do you use them?_____Do they help? _____In what ways?_____

_____

Have you ever been told that you have curvature of the spine or scoliosis and if yes, how old were you when you were first told this? _____

Do you wear braces on your teeth and if yes, when did you get them?

_____how much longer do you wear them? _____

If you said no, have you ever worn braces on your teeth? _____

Do wear a night guard or bite splint? _____

Were there any birth traumas when you were born such as a C-section or forceps delivery?_____Any other issues, deformity or complications that you know of?_____

Have you ever worn leg braces?_____corrective shoes?_____

If you have ever *given* birth, how many times? _____ type of delivery?

_____Complications? _____

Did you receive any massage therapy before, during or after pregnancy?

Describe_____

Does anyone in your biological family suffer from any of the same aches, pains or health issues that you do? Y or N if yes, who and what? _____

Are there any highly stressful emotional events currently in your life such as marriage, divorce, a loss through separation or death, difficult relationships, relocation, new job, prolonged depression, unhappiness, you just won the lottery etc. (The nervous system does not differentiate *where* over stimulation comes from, it simply monitors the sum total) Y or N

Have there been any of these types of stimulants over the past 2 years? Y or N

If yes, are you currently working on reducing this stress? Y or N

Are you under the care of a psychiatrist/psychologist or another licensed professional for the effects? Y or N

May we contact your current health care practitioners in order to get further information, copies of x-ray reports, MRI results, etc., if we deem it necessary while working with you? Y or N And if no, what is your objection based on?_____

_____

Lifestyle:

Describe the type of work you do and any daily activities that occur repetitively for hours at a time (i.e. sitting, driving, standing, bending, lifting, typing, reading, cradling phones, holding a baby, sewing, etc.) _____

_____

_____

Do you stretch your entire body 3 or more times a week for at least 20-30 minutes at a time (lengthen, not strengthen)? Y or N

Or do you stretch parts of your body every now and then, before or after exercise for 2-10 minutes at a time? Y or N

If you stretch just parts, what parts do you tend to focus on?

_____

_____

Do you lift weights or engage in resistance workouts 2 or more times a week? Y or N

Do you do cardio vascular exercise (speed walking, running, jogging, biking, hiking, swimming or other wise get your heart rate up for at least 20-30 minutes at a time) 2 or more times a week? Y or N

Do you do other types of activities such as yard work, basketball, softball, golf, hockey, soccer, or any other kind of sporting activity 2 or more times a week? Y or N

Are you a "weekend warrior" who does not stretch or exercise regularly but will have blasts of movement or activity on a weekend, once a month or a few times a year? Y or N

Or are you a total couch potato who could care less about stretching and exercise? Y or N

How would you rate your overall fitness Strength, flexibility and cardiovascular endurance on a scale of 1-10 (10 high)? S _____ F_____ C_____

Do you have any scars or adhesions from previous injuries or surgeries and if so

where? _____ Do you have spider or varicose veins

anywhere? _____If

yes, how old were you when you first noticed them? _____

How many glasses (16-20 oz) of plain water do you drink daily?_____

Would you say that you have a well balanced diet of fruits, veggies, protein, carbs, healthy fats, etc., each day? Y or N

Are you vegetarian or a meat eater? _____if meat eater:

Chicken, fish, pork, venison, beef, (circle all that apply) other_____

Do you have processed sugar in your diet on a daily basis? Y or N

Do you have caffeine on a daily basis and if yes, how much?_____

Alcohol? Servings per week? _____

Do you use artificial sweeteners? Y or N

Do you smoke? Y or N Chew tobacco? Y or N

Do you have other dietary or recreational habits considered to be unhealthy? Y or N

List all medications (both prescription and over the counter) currently taken and the frequency and dosage of each_____

_____

_____

List all daily vitamins, minerals or herbal supplements _____

_____

We will make every effort to assist you out of pain by educating you about your body, wellness techniques, preventive care, and other things on the market for pain relief while you are at this clinic. Because of this approach, it is important for us to know where you stand before we make any suggestions or referrals to you based on our impressions. Regarding your history, daily habits, diet, activities, and even your current health care providers how open are you to making changes if what you are currently choosing does not appear to be producing the desired results?

Wide open Somewhat open Not very open Will need more information

Thank you. Please sign indicating your consent to receive our hands-on assistance with neuromuscular therapy, myofascial release, AIS and other associated therapies and information.

Signature _____ Date _____