REGISTRATION & MEDICAL HISTORY FORMS

Instructions:

1. **Please download and "save" this form to your computer.**
2. **Fill in the form on your computer and "save" again. Use** Adobe Acrobat Reader DC**. Do *not* fill in in your browser – what you type will not be saved.**
3. **Attach the saved form to an e-mail sent to** kate@myofascialpainsolutions.net**.**

Today's Date	

CONTACT INFORMATION

First Name		Middle Init.		Last Name	
E-mail Address					
Address 1					
Address 2					
City		State		ZIP Code	
Phone Number		Cell	Home	Work	

PERSONAL INFORMATION

Birth Date		Age	
Referred By			

What type of case is this?		Personal	Worker's Compensation
Date of injury			

Employer (for worker's comp.)	Occupation	Current Work Status

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MEDICAL INSURANCE INFORMATION (Worker's Compensation Only)

Insurance Company	Claim Number	
ID/Group Number		
Insurance Company Address	Insurance Company Address 2	
City	State	Zip
Adjuster's Name		
Phone Number	Fax Number	

PERSONAL VITAL STATISTICS

	Feet	Inches
Height		

	Lbs.
Weight	

Adults you live with:

Spouse Partner Roommate(s) Live alone Other

Do you have children?

Yes No

Past	Current		Past	Current	
		Asthma			Eating disorder
		Allergies			Candidiasis
		Bronchitis			Depression
		Emphysema			Chronic fatigue
		Angina			Irritable bowel
		Diabetes			Endometriosis
		Stroke			Dyslexia
		Phlebitis			Memory loss
		High blood pressure			Polio
		Low blood pressure			Cancer
		Varicose veins			Seizures
		Migraines			TMJD
		Chronic constipation			Scoliosis
		Hypoglycemia			Short leg
		Hemorrhoids			Arthritis
		Severe diarrhea			Osteoporosis
		Alcoholism			Long 2nd toe
		Drug abuse			Other

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Please describe any major accidents or surgeries you have had:

PRESENT INJURY

Please describe the main diagnosis and symptoms bringing you in for treatment:

When did you first notice your symptoms?

Please describe any physician and therapy appointments you have had for this injury:

Please list all medications/dosage that you are currently taking:

Please select all choices below that help relieve your pain:

Ice Heat Stretching Exercise Medication Therapy Nothing helps

Notes (Office Use Only):

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1. OCCUPATIONAL/WORKLOAD

NORMAL number of hours worked a day	NORMAL number of days worked a week	REDUCED number of hours worked a day	REDUCED number of hours worked a week

Number of breaks you take a day

Please enter the percentage of your day (10-100%) you spend doing the following:

Sitting	Standing	Walking	Driving	Lifting	Reaching	Writing	Typing	Mouse	Phone

2. MECHANICAL/ERGONOMIC

Do you use a computer in your work? Yes No

Please check the kinds of equipment you use:

- Ergonomic chair
- Standard keyboard
- Split keyboard
- Other keyboard
- Standard mouse
- Other mouse
- Voice-activation software
- Standard phone
- Phone headset
- Other phone

What other tools do you use in your profession?

Are you on modified duty?

Yes No

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3. EXERCISE/FITNESS

What time of day (e.g. 6 a.m.) do you do the following activities?

Activity	Time
Wake up	
Bathe/dress	
Fix/eat breakfast	
Drive/take transportation	
Have lunch	
Take a break	
Come home	
Fix/eat dinner	
Go to sleep	
Exercise/stretch	
Watch TV	
Read	
Play instrument	
Hobby	

Please select the activities that cause you the most pain:

Wake up
Bathe/dress
Fix/eat breakfast
Travel to/from work/appointments/class
Work/appointments/class
Have lunch break
Come home
Fix/eat dinner
Go to sleep
Exercise/stretch
Drive/take transportation
Watch TV
Read
Play instrument
Hobby
Other

Does exercise *help* or *aggravate* your condition?

Help
Aggravate

Have you recently *stopped* or *started* exercising?

Stopped
Started
N/A

Do you enjoy exercising?

Yes
No

Do you *drive* or *take public transport?*

Drive
Take public transportation
Both
Neither

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4. STRESS

Are you under stress at

Work School Home Not stressed Other

Has your workload increased in the past year? Yes No

5. SLEEP

On average, how many hours do you sleep each night?

4 hours
5 hours
6 hours
7 hours
8 hours
9 hours
10+ hours

Does this feel like enough sleep for you?

Yes
No

Is your bed comfortable?

Yes
No

Please select your bed type:

Mattress
Futon
Waterbed

My bed is…

Hard
Medium
Soft
Old

How many pillows do you use?

1
2
3+

Please select the words that describe your pillows:

Hard
Medium
Soft
Old
Foam
Down
Buckwheat
Soba
Bodypillow (long)
Cervical

Do you have trouble with…

Restless legs
Frequent urination
N/A

Do you wear…

Splint(s)
Night brace(s)
N/A

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Do you have trouble with…
Falling asleep
Staying asleep
Waking up
N/A

What awakens you most often?

6. DIET

Please list all vitamins, herbs, and dietary supplements that you take:

At which meals would you eat or drink the following?

	Breakfast	Lunch	Dinner	Snacks
Meat				
Poultry				
Fish				
Tofu				
Beans				
Fruit				
Dairy				
Vegetables				
Pasta				
Grains				
Sweets				

How many cigarettes, cigars, or pipes do you smoke a day?	
How many cups of tea, coffee, or caffeinated soda do you drink a day?	
How many glasses of water/fluid do you drink a day?	

Do you drink alcohol? Yes No

7. ASSOCIATED MEDICAL CONDITIONS

Please list any allergies that you have:

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Please check all of the following that you experience:

Ear ringing
Ear pressure
Ear clicking
Earaches
Ear blockages
Hearing loss
Teeth grinding
Teeth clenching
Teeth grating
Jaw popping
Jaw hard to open
Jaw locks open
Dizziness
Nausea
Fainting
Nervous tics
Vision changes
None of the above

Do you wear…?

Glasses
Contact lenses
Foot orthotics
None of the above

Have you ever had extensive dental work?
Yes No

Do you wear orthodontics?
Yes No

PLEASE READ CAREFULLY:

We are required to have your permission to send progress reports to your doctor(s), other therapist(s) and your insurance company. Please initial the appropriate slots to grant your permission to do so. Thank you.

I hereby give permission to send a progress report to the following:

My doctor(s)	**My therapist(s)**
Please sign or initial to o.k.	*Please sign or initial to o.k.*

Today's Date					
First Name		Middle Init.		Last Name	

My insurance company

Please sign or initial to o.k.

I agree that all information contained in this medical history is true.

Please sign or initial.

PLEASE "SAVE" THIS PDF FORM AND E-MAIL IT TO

kate@myofascialpainsolutions.net