PATIENT INFORMATION (confidential) for Mary Jo Smiley CMTPT

NAME _____ DATE _____

Address _____

Email _____ (mobile) phone_____

Birth date _____ Age _____ accident date _____

REFERRED BY: Dr or friend?_____ W/ script Y/N_____

Insurance company & adjuster _____

PLEASE NOTE: The questions here are intended to help me to help you. Please answer all of the questions as they may relate to the cause or perpetuation of trigger points or/and your injury and pain. Please take the time to answer the questions fully. Use the back if you need to give complete answers. If you would like to change or add to an answer at any time in the future, please inform me of the changes. They may be important. If you have not been in an accident, simply mark "NA".

PAIN Indicate pain, numbness or other problems in the following areas.

_____ Unexplained or sudden onset Calf pain? _____Anti-coagulants, blood thinners?

_____ Unexplained dizziness, numbness, loss of strength or balance, speech problems?

Right	Left		Comments	Right	Left		Comments
___	___	Headache	_____	___	___	Neck Pain	_____
___	___	Migraine	_____	___	___	Shoulder	_____
___	___	Arm and Hand	_____	___	___	Chest area	_____
___	___	Abdomen	_____	___	___	Upper Back	_____
___	___	Thigh, Leg, Feet	_____	___	___	Mid Back	_____
___	___	Hip, Buttocks, Groin	_____	___	___	Low Back	_____

When (how long ago) did the pain first start? ____ Years ___ Months Days _____ ago?

Was the onset Sudden ____ Gradual _____ Other ?_____

PLEASE LIST ALL ACCIDENTS AND DATES

Please describe in DETAIL any and all accidents, injuries, or contributing factors that you feel have contributed to your present condition. Use extra paper if needed. Please describe your position in auto and impact direction. Describe accident or condition if other than auto accident.

What were you doing when accident occurred?_____

_____

Speed of vehicles_____ Impact direction _____

Driver or passenger? _____ Damage to vehicle _____

Ambulance? _____ Did you got to ER? _____ When?_____

TESTS

Date performed and results? Indicate area of test (neck, arm, back etc) X-ray_____
CT Scan _____ MRI _____ EMG _____ Bone Scan _____
Blood Tests _____ Other _____

Are you involved in litigation because of these injuries? If so, Attorney's name & contact info
_____
_____

YOUR COMMON DAILY OR WEEKLY ACTIVITIES BEFORE INJURY (Work, hobby, play etc.)
_____
_____

Have you had to stop any of these activities because of pain or discomfort? List any changes
_____
_____

What is your typical pain level? _____ How long has it been at this level? _____
(0 to 10, 0 = no pain 10 = disabling pain or worst pain imaginable)

Does this pain occur: Only during activity ____ At rest ____ Always ____ Intermittent _____
If during activity, what activity exacerbates the pain? _____
Does the level of pain change during the day? _____ If so how?
_____
What has given you the most relief? (professional treatments, self care, heat, meds?)
_____
_____
_____

PREVIOUS TREATMENT FOR THIS PROBLEM

What specialists, doctors, or other health care providers have you seen concerning this problem and what was their diagnosis? PT, Chiropractor, MD?
_____
_____
What was done by these providers that was helpful?
_____

MEDICATIONS & SUPPLEMENTS

Please list all medications, herbs, vitamins and supplements that you take and note whether you take them regularly or occasionally. (R / O)
_____
_____

EXERCISE

Do you exercise? _____ How often? _____ Type of activity? _____
Have you had to reduce, change or stop your normal activity? _____

SLEEP AND REST

Do you sleep well ?_____ Favorite sleeping position? _____
Have your normal sleep patterns been disrupted because of this pain? _____
Hours you normally sleep ____ Now? _____ Times you wake due to pain? _____
When you get up do you feel: rested _____ stiff and sore ____ like you never slept _____
Other? _____
Mattress type _____ Pillow type? _____ How many? ____Were are the pillows?_____

GENERAL HEALTH

How would you describe your general health?
_____
Have there been any notable changes in the last year or so? _____

Describe your typical diet, is it healthy?
_____
_____
How much caffeine do you consume daily? _____ water you drink daily_____0z
Do you use artificial sweeteners or diet drinks? _____ How much? _____

PERSONAL

Dominant Hand? R ___ L ___ Both ___ excessive use of one side (mouse, work)? _____
How would you describe your emotional/mental health? _____
_____
Stress Levels: High ____ Medium _____ Low _____ Are they much higher in any aspect of your life? _____Has there been an increase in stress levels due to the accident?_____
_____
_____

PLEASE LIST SURGERIES, INJURIES (WITH DATES OR YEAR) CHILDHOOD TO PRESENT

_____
_____
_____
_____

LIST MEDICAL OR ANY OTHER CONDITIONS THAT I SHOULD CONSIDER WHILE TREATING YOU.

_____
_____
_____
_____
_____

Have you had or do you experience any of the following:

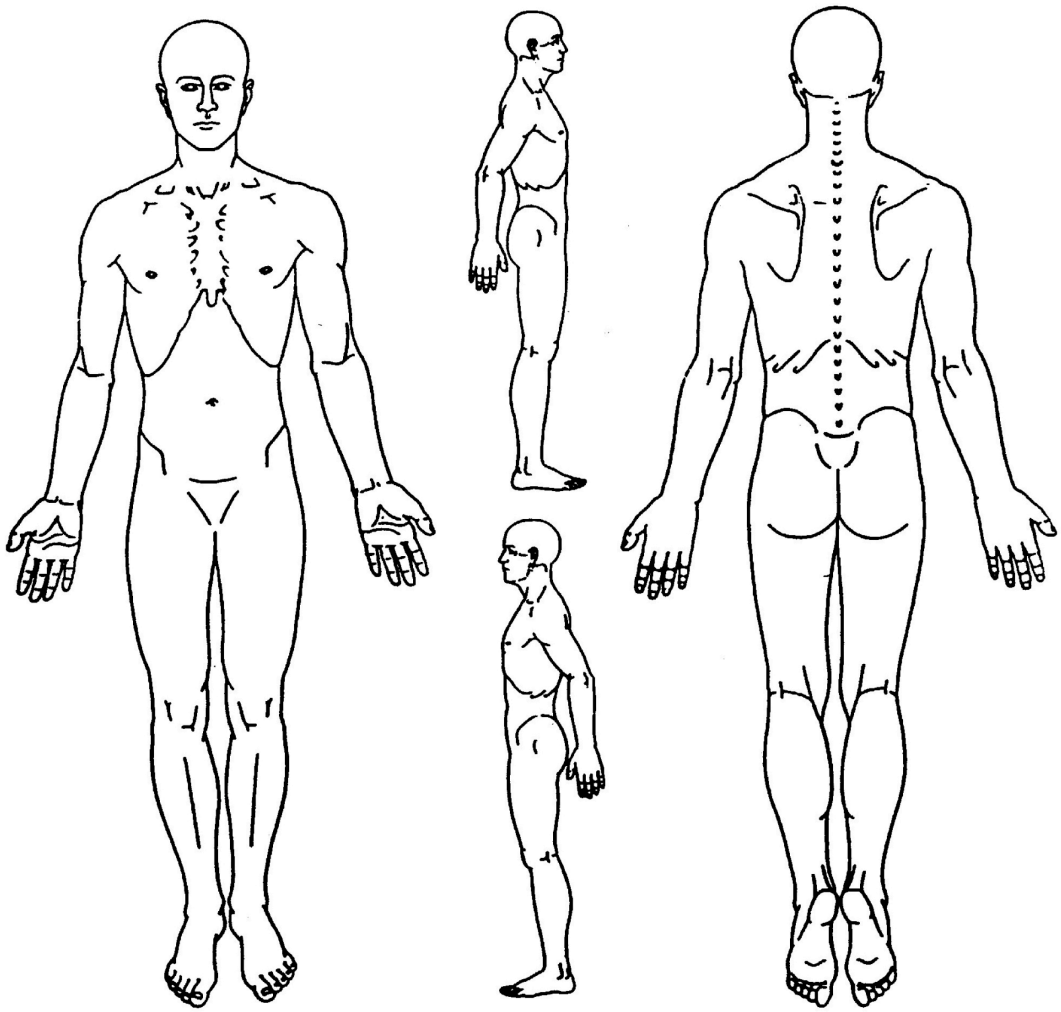
___ low body temp? ___ your normal temp? ___ cancer? ____ where? _____
___ clenching of teeth? ___ grinding of teeth at night? ___ TMJD? Jaw popping, difficulty opening?
___ ringing , pressure in ears? ___ dizziness or vertigo? _____ excessive bruising
___ whiplash? ___ phlebitis or blood clots? ___Unexplained CALF PAIN ___ numbness?
where? _____ ___ scoliosis? _____Sciatica? ____ osteoporosis?
_____ arthritis? Where? _____ ___ food allergies? _____
chemical sensitivities what? _____
____ Pain starting after use of Cholesterol drugs? _____ severe or recurring headaches?

Please list any pains, discomfort, or symptoms that may or may not be related to this problem.

_____

_____

_____



TOUCH ISSUES

Because of the nature of trigger point therapy and medical massage, I may be touching many areas of your body that you may not be accustom to being touched. Muscles are everywhere and any of them can be dysfunctional. This may include muscles in the groin area, under and around chest/breast tissue, lower abdominal/pubic bone region. If there is ever any question as to why I am working where I am, or a discomfort (physical or emotional) with me touching you in that area, PLEASE IMMEDIATELY voice that concern. I will explain why I am working there, abstain or show you how to treat the area yourself if possible.

Each and every persons body is different, I can not feel your pain. You MUST express verbally if my pressure is too hard. Many areas of the body are more sensitive than others and due to the nature of trigger points being hypersensitive, a specific area may be "exquisitely" painful whereas the muscle beside it may not. It is very important that we communicate. The words "stop" "back off" "ease up" mean just that, "that hurts" I consider to mean "that is a good spot" and may not reduce the pressure unless we have established vocabulary.

Soreness and a "bruised" sensation are common in the days following a treatment. Please let me know if you experience this soreness. This effect may be lessened by consuming extra quantities of water after the treatment. Performing stretches to keep the muscles lengthened will also help. Stretches are not to be done to the point of pain.
Please inform me if you are experiencing discomfort during or after the session and I will reduce the pressure and stretches.

PLEASE LET ME KNOW IF YOU HAVE ANY QUESTIONS THAT HAVE NOT BEEN ANSWERED. Understand that the patient (You) are a very important part of the therapy. The suggested "homework" stretches are very important to recovery and please be willing to do them to the best of your ability. If you are not sure about positioning or any other concern please will ask for additional instruction. NO STRETCH SHOULD BE PUSHED TO THE POINT OF PAIN. STRETCHES SHOULD FEEL PLEASANT AND NEVER PAINFUL.

PLEASE GIVE 24 HOURS NOTICE IF YOU CAN NOT KEEP YOUR APPOINTMENT. You may be charged $70 if you fail to do this. In the event of an emergency or uncontrollable events such as inclement weather or illness please call as soon as possible and I may wave the charge.

PLEASE CALL MY PERSONAL NUMBER IF YOU NEED TO CANCEL,
MY CELL PHONE NUMBER IS 724-494-1468 PLEASE WRITE IT DOWN AND PUT IT IN YOUR PHONE. Thank you.

I have read and understand the preceding paragraphs. I will inform Mary Jo verbally if there needs to be a change in pressure during the treatment or if after the treatment I find that I am in excessive discomfort. I will inform Mary Jo if any new injuries or changes in medical conditions occur during the course of treatment.
PLEASE GO BACK AND INITIAL THE END OF EACH PARAGRAPH ON THIS PAGE.

I understand that massage and body work are not a replacement for proper medical care and that no diagnosis will be made or implied. No part of any conversation during the treatment session should not be considered medical advice.

Sign _____ Date _____