

## 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 &amp; 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? _____			_____	_____	_____
Was the onset    Sudden _____    Gradual _____			_____	_____	_____
			_____	_____	_____

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.

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 What were you doing when accident occurred? \_\_\_\_\_

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 Speed of vehicles \_\_\_\_\_ Impact direction \_\_\_\_\_

Driver or passenger? \_\_\_\_\_ Damage to vehicle \_\_\_\_\_

Ambulance? \_\_\_\_\_ Did you get 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 \_\_\_\_\_ Oz  
 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:

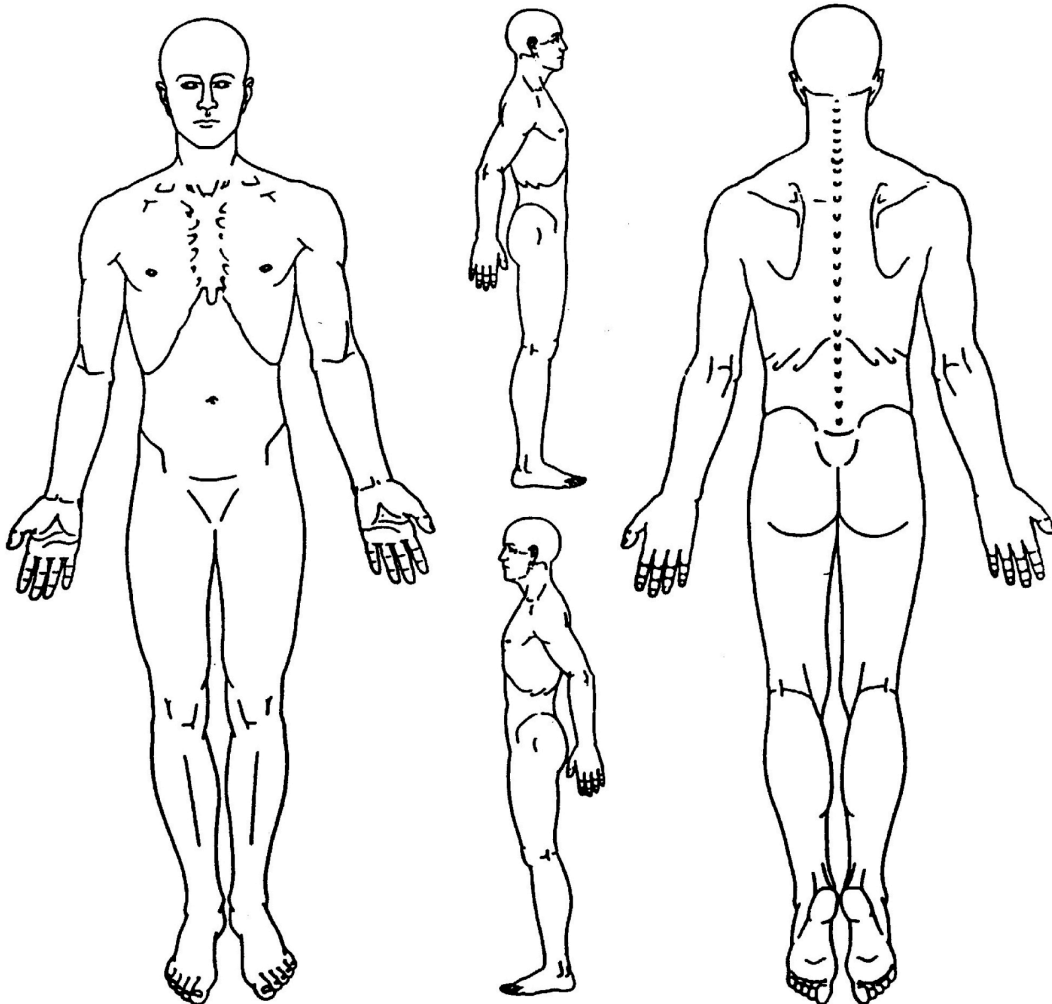
\_\_\_ low body temp? \_\_\_ your normal temp? \_\_\_ cancer? \_\_\_ where? \_\_\_\_\_  
\_\_\_ clenching of teeth? \_\_\_ grinding of teeth at night? \_\_\_ TMJD? Jaw popping, difficulty opening?  
\_\_\_ ringing , pressure in ears? \_\_\_ dizziness or vertigo? \_\_\_ excessive bruising  
\_\_\_ whiplash? \_\_\_ 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.

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## 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 accustomed 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/pubis 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 person's 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 \_\_\_\_\_