



Myofascial Intake Form

Personal Medical History

Name _____

Date _____

Please describe the condition you are seeking treatment for and give a brief history—including onset:

Check pain in the following areas (*Please PUT A STAR in front of worst pain):

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 & feet

What are your goals for treatment?

What other treatments have you tried for your pain?

My regular exercise is:

My goals for exercise are

Name _____

Date _____

Are you aware of having or have you been diagnosed as having any of the following conditions or symptoms. Please circle and indicate C for current and P for past next to the condition where appropriate.

Asthma	Overweight	Memory Loss
Allergies	Underweight	Short Leg
Chronic Cough	Phlebitis	Scoliosis
Sinusitis	Hypertension	Arthritis
Migraines	Hypotension	Osteoporosis
Fibromyalgia	Depression	Polio
TMJD	Alcoholism	Cancer
Herpes	Drug Abuse	Seizures
Dental Problems	Clench/Grind	Stroke
Chronically cold	Sleep disorder	Cardiac Arrythmia
Chronic Fatigue	Sleep Apnea	Angina
Diabetes	Auto Immune	Thyroid disorder
Dizziness	Fainting	Vision changes
Strength changes	Tinnitus	Glasses
Abdominal pain	Bloating	Pelvic Pain
Chronic prostatitis	Painful urination	Painful Defication
Chronic diarrhea	Incontinence	Constipation

Women

Pregnancies	Menstrual Pain	Urinary frequency
Urinary Urgency	Stress Incontinence	Pelvic Pain
Menopause	Hormone Replacement	

Please list all other medical conditions that you have: _____

I smoke _____ cigarettes, cigars, pipes per day.

I drink _____ cups of coffee/tea/caffeinated beverages per day.

I drink _____ alcoholic beverages per day.

I drink _____ glasses of milk, diet soda, water, per day.

I chew _____ sticks of gum per day.

Name _____

Date _____

I sleep _____ hours per night.

I go to sleep at _____ and wake up at _____

My sleep quality is _____ great _____ good _____ poor

I have trouble _____ falling asleep _____ staying asleep _____ waking up

When I wake up I feel _____ well rested _____ still tired

I sleep on my _____ back _____ Stomach _____ sides

I get up to go to the bathroom _____ times per night

I have _____ sleep apnea _____ insomnia _____ uncomfortable bed

What is your: Height: _____ Weight _____

Are you: Left-handed _____ Right-handed _____

Are you currently working? _____ No _____ Full Time _____ Part Time

Did you work before your symptoms began _____ Yes _____ No

Did your pain make you stop working _____ Yes _____ No

I watch _____ hours of TV per day.

I play _____ hours of videogames or computer games/web surfing

I commute _____ mintues/hours to work per day.

My hobbies are:

My pain is worse when _____ sitting _____ standing _____ walking _____ sleeping

My pain is worse when _____ moving _____ sedentary

Other things that make my pain worse:

Things that make my pain better:

Name _____

Date _____

List all diagnostic tests you have had (and results) for your current pain/condition:

List all past surgeries and approximate dates:

List all past injuries and approximate dates:

List prescribed medications that you are currently or have recently taken:

Medication

Effects

List over the counter medications and dietary supplements that you are currently or have recently taken:

Supplement

Effects

Patient Signature _____