CHICAGO CENTER FOR MYOFASCIAL PAIN RELIEF

Please fill this form out before you arrive for your first appointment, it will save time when you are with us.

Contact Information

TODAY'S DATE:_____

NAME	
ADDRESS:	
PHONE NUMBER:	
D.O.B	
Your email:	
Diagnosis:	

Who referred you to us?

Name:	**SPECIALTY:**
Address:	
Phone:	
email:	

Please give us the Name and contact information for other Physicians / Therapists you work with:

1) Practitioner name: _____
   a. Name and type of Practice /clinic: _____
   b. Their phone number: _____
2) Practitioner name: _____
   a. Name and type of Practice /clinic:_____
   b. Their phone number: _____
3) Practitioner name: _____
   a. Name and type of Practice /clinic:_____
   b. Their phone number: _____

Your Name:_____ Date:_____

EMPLOYER INFORMATION
COMPANY NAME
ADDRESS:
PHONE NUMBER:
JOB TITLE:
email:

_____

Insurance Information
Carrier Name
Member Number:
Group Number:
Co-Pay Amount:
Insurance Phone #:
email:
Primary Care Doctor (omit if same as referral source on first page)
Name:
SPECIALTY:
Address:
Phone:
email:

Chicago Center for Myofascial Pain Relief
We Understand Your Muscle Pain

Dr. Renee S Hartz Pre-appointment History

Please complete this form before your evaluation nd bring it with you to your appointment. Thank you.

Name: _____ **Today's Date** _____

Address : _____ **Birthdate** : _____
: _____
Employer : _____ **Cell ph #:** _____
Occupation : _____

What is your Chief Complaint: (#1 problem)

_____

How long have you had this problem?

_____

List all injuries, accidents, procedures or surgeries, starting with the most recent and going back as far as you can remember. **EVERYTHING** matters, so please try be as thorough as possible.

Approximate Date	**Description of Injuries/Accident/Surgery/ Procedure**

Have you been told by a physician that you have the following:

Herniated or Bulging Disks	Yes / No	Osteoporosis/Osteopenia	Yes / No
Spinal Stenosis	Yes / No	Arthritis	Yes / No
Scoliosis	Yes / No	Hypermobility Disorders	Yes / No
Fibromyalgia	Yes / No	Heart Disease	Yes / No
Carpal Tunnel Syndrome	Yes / No	High Blood Pressure	Yes / No
Diabetes	Yes / No	Kidney Disease	Yes / No
Thyroid problems	Yes / No	Stroke	Yes / No
Auto-immune disorders	Yes / No	Circulatory Problems	Yes / No

Are you ___ right-handed or ___ left handed?

Do you wear shoe orthotics? Yes / No. If yes, how long? _____

Do you now, or did you as a child, prefer to sit on one leg? Yes / No

Do you have any food sensitivities? Yes / No. If yes, please list:
_____

Do you have any allergies? Yes / No. If yes, please list:
_____

Are you pregnant? Yes/No.
Have you been through menopause? Yes/ no When?_____

List any medications you are currently taking:
1. _____ additional list here:
2. _____
3. _____
4. _____
5. _____

List any supplements or vitamins you are currently taking:
1. _____
2. _____
3. _____
4. _____
5. _____

List any medications you have tried in the past and the reason you stopped taking it:
1. _____
2. _____

Please circle other current therapists/ therapies, and underline any past therapies you have tried:

Chiropractic PT Tens Unit Ultrasound Cortisone Injections
Acupuncture Massage Dry Needling Other: _____

What is your occupation:_____

Is your pain affecting your work performance? If yes, Describe:

_____

Are you immobile for long periods? If yes, describe:

_____

Does anything increase your pain? If yes, please explain.

_____

_____

Does anything relieve your pain, e.g., medication, heat, cold?

_____

Is the pain associated with any movements you make?

_____

Jaw/Facial Pain (only complete this section if you have jaw/facial pain)

Do you have TMJ? Yes / No
Do you have jaw pain associated with chewing or yawning? Yes / No
Do you clench or grind your teeth? Yes / No
Do you wear a night guard or mouth splint? Yes / No
When was your last dental appointment? _____
When was your last eye exam? _____
Do you wear bifocals/trifocals? _____

Home Stress

Do you have childcare or home-tasks? Yes / No
Are you immobile for long periods at home? Yes / No
Do you read while laying on a couch/bed (neck flexed forward)? Yes / No

How stressed are you from day to day (please circle)?

High High-Medium Medium Medium-Low Low

Sleep

What position do you most often sleep in? Circle and give % of night in each.

Back	Side	Stomach	Arms Overhead
Half-stomach/half side	Fetal position	Pets in bed	Spooning with partner

Do you use pillows under or between the knees or behind your back? Yes / No

How many hours of sleep do you typically get? _____

Do you have difficulty falling asleep? Yes / no
Do you wake up often in the middle of your sleep? Yes / no
Do you wake up feeling tired? Yes / no

Exercise

Are you able to exercise? Yes / No
If yes, what type of exercises do you do and how frequently? Please be specific.

_____

If not, what are your reasons for not exercising?

_____

What kind of exercises do you think you would enjoy doing?

_____

Smoking/Alcohol/Caffeine/Sugar

Do you **smoke** or use tobacco products? Yes / No If yes, what kind and how much per day?

_____

Do you drink **alcohol**? Yes / No If yes, what kind and how often?

_____

Do you drink **caffeinated beverages**? Yes / No If yes, what kind and how often?

_____

How much water do you drink per day? _____

What are your goals for treatment with us?

1. _____
2. _____
3. _____

Thank you for taking the time to complete this form.
We look forward to working with you on your journey toward better health!
Dr Renee Hartz and the Team at Chicago Trigger Point Center
1-773-628-7654 www.TriggerPointCenter.com

Please bring any test results/films/reports that may be relevant to your condition.

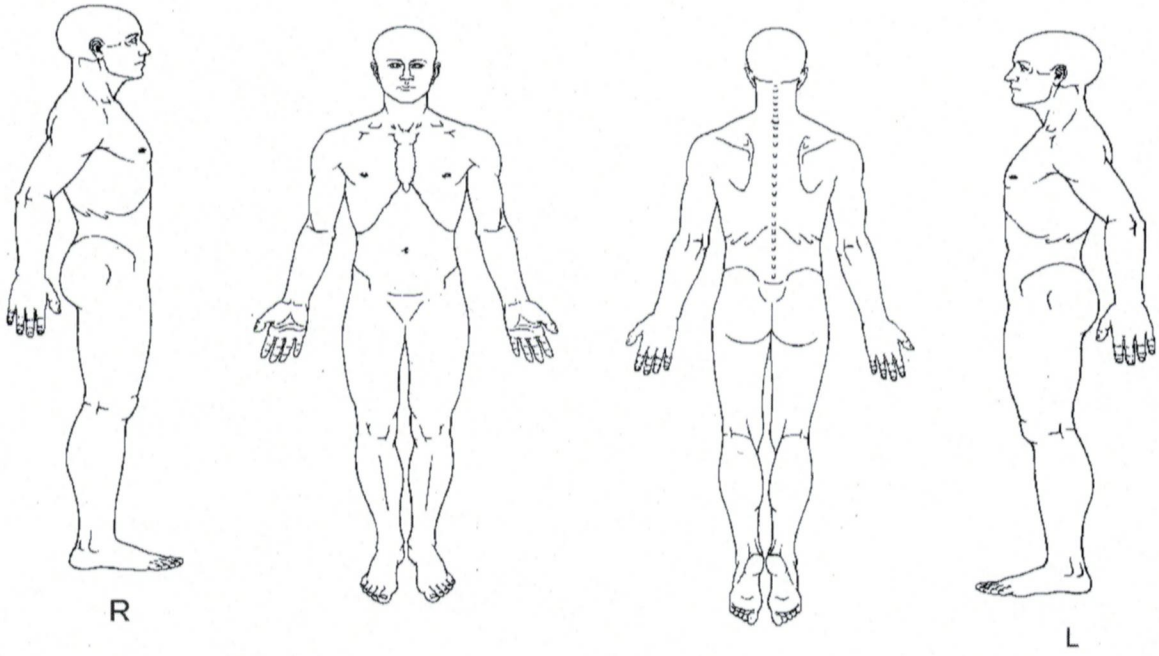
Chicago Center for Myofascial Pain Relief

Myofascial Trigger Point Therapy Symptom Chart

Name: _____

Date: ____ / ____ / _____

* Please indicate on the drawing below where your pain is **today** with corresponding pain numbers. Use lines pointing to specific regions to separate pain levels and sensations in different areas and number accordingly. Feel free to add any descriptive words specific to any region. For example, your shoulder blades could be an 8/10 and "burning" while your front of shoulders are 3/10 and "nagging".



2. Please place an "X" in the table below at a point that best corresponds to the general intensity of your overall pain.

0	1	2	3	4	5	6	7	8	9	10
No Pain				Moderate Pain					Excruciating Pain	

3. Please place an "X" in the table below at a point that best corresponds to the general degree of dysfunction due to your pain.

0	1	2	3	4	5	6	7	8	9	10
No Dysfunction				Moderate Dysfunction					Complete Dysfunction	

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