Myofascial Pain Treatment Center, LLC

203 Arlington Street, Suite 1
Watertown, MA 02472
781-894-9430

Personal Medical History

Name_______________________________

Address_____________________________

____

Contact: home (____)__________________ ____OK to leave message
work (____)__________________ ____OK to leave message
mobile (____)_________________ ____OK to leave message
Email ________________________ ____OK to contact me

My preferred method of communication/ appointment confirmations is:
___home phone ___cell phone ___text ____email

Date of Birth ________________ Current Age________

Occupation______________________________

Employer________________________________

Primary Care Physician_____________________

Referred by_______________________________

Spouse/Partner___________________________

In case of emergency contact ____________________ at
(___)________________

Signature____________________________ Date_____/_____/____

Name________________________ Date___/____/____

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

What are your goals for treatment?

What other treatments have you tried for your pain?

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

List all past surgeries and approximate dates:

Name________________________ Date___/____/____

List all past injuries and approximate dates:

____

____

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:

____

____

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

Medication For what condition Side effects?

____

____

____

____

List ***over the counter*** medications and/or supplements that you currently or have recently taken:

Supplement For what condition? Side effects?

____

____

____

Please list ***all*** other medical conditions that you have (even if you are not seeking treatment for them here):

____

____

____

Name________________________ Date___/____/____

Are you aware of having or have you been diagnosed as having any of the following conditions or symptoms please check and indicate ***C*** for current or ***P*** for past 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_________ Abdominal pain_______
Bloating__________ Pelvic Pain___________ Chronic prostatitis_____
Painful urination______ Painful Defecation______ Chronic diarrhea_______
Incontinence_________ Constipation___________

For Women:
Pregnancies___________ Ages of children:____________
Menstrual Pain________ Urinary frequency_____
Urinary Urgency_______ Stress Incontinence_____ Pelvic Pain_______
Menopause___________ Hormone Replacement_________

I smoke______ cigarettes, cigars, pipes per day.
I drink _______ cups of coffee/tea/caffeinated beverage per day.
I drink _______ alcoholic beverages per day.
I drink _______ glasses of fluid per day.
I chew _______sticks of gum per day.
What is your: Height____________ Weight_______________
Are you: left handed ______ right handed_____

Name________________________ Date___/____/____

My regular exercise is:

____

____

My goals for exercise are:____

My hobbies are:

____

____

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
____other sleep condition (specify)

Do you wear glasses? ____No _____Yes If yes, are they (circle):
bifocal progressive reading computer

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
What are your main activities at work?

I commute ____________minutes/hours to work per day.

I watch ______hours of TV per day
I play _______ hours of video game or computer games/web surfing (non-work) on my ___smart phone ___ipad (or similar) ___laptop ___desktop
I ___do ___do not use a headset/ear piece for telephone or cellphone
I send (#) ____ texts daily

Patient Signature:______________________________