PATIENT INFORMATION SHEET

Brynn A. Adams, LMT, CMTPT Today's Date: _____

Personal History (Please print legibly.)

Name: _____
Last First Middle Initial

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ May we contact you at work? Y N

Email Address: _____ Date of Birth: _____

Sex: M F Marital Status (Circle): S M W D

Emergency Contact: _____ _____ _____
Relationship Phone

From whom or how did you find out about our office? (referral, website, etc.): _____

Medical

Family Doctor: _____ Address: _____

Are you under chiropractic care? Y N If so, with whom? _____

Are you allergic to any medications? (Please list) _____

What medications are you currently taking and why: _____

_____

Are you on any cholesterol medication? Y N If yes, which one? _____

Do you bruise easily? Y N Do you use orthopedic devices (ie: foot lifts)? Y N

Please list any surgeries and/or medical diagnosis(es) you have received as well as accidents sustained, even if you think they are not relevant. (Example: diabetes, cancer, C-section, car accident, high blood pressure, varicose veins, thrombosis, heart disease, etc.) _____

_____

_____

_____

_____

_____

Females only: Are you pregnant? Y N If yes, how long? _____ Months
Have you had a C-Section or natural birth before? Y N How many C-Sections? ____ Natural Births? ____
Are you on birth control? Y N If yes, what type? _____

Vocational

Present Occupation: _____

Do you spend a lot of time on the phone? Y N If yes, how many hours in a given day? _____ Hours

Do you work on a computer? Y N If yes, how many hours in a given day? _____ Hours

Job stress level? (Circle) High Medium Low Hand dominance (Circle): Right Left

Personal stress level? (Circle) High Medium Low

Health/Nutrition

How many ounces do you drink of the following daily? Water: _____ Regular Coffee: _____ Decaf. Coffee: _____

Regular Tea: _____ Decaf. Tea: _____ Herbal Tea: _____ Soda: _____ Diet Soda: _____ Juice: _____

Do you drink alcohol? Y N If yes, how often? _____

Do you use diet or sugar-free products (other than soda)? Y N If yes, how often? _____

Do you use tobacco products? Y N If so, how often? _____

Do you take/use drugs (other than prescription and/or over-the-counter)? Y N If yes, how often? _____

Do you take any herbal or nutritional supplements? Y N Which brand(s)? _____

Please list type (ie: fish oil or Vitamin C, etc.): _____

_____

Sports/Hobbies

Do you currently play any sports or have any hobbies? Y N

If yes, which sports/hobbies? _____ How many times per week? _____

Have you had to quit any sports or hobbies because of pain/dysfunction? Y N

Which ones? _____ How long ago? _____

Exercise/Weight Training

Do you currently have an exercise routine (even if not consistent)? Y N

Approximately how many days per week do you exercise? _____

Do you engage in isometric exercises? Y N Are you training at a gym? Y N

Do you use a treadmill? Y N If yes, is it level or inclined? _____

Do you use free weights? Y N Do you practice yoga or tai chi? Y N

Other: _____

Sleep

How many hours of sleep do you average per night? _____ Hours Do you snore? Y N

Do you sleep straight through? Y N If no, why do you wake up? _____

Has anyone ever told you that you stop breathing while you sleep? Y N

Are you tired during the day? Y N Do you use a pillow? Y N If so, how many? _____

How old is your mattress? _____ Years. Does your bed sag anywhere? Y N

Sleep position? (ie: stomach, side or back) _____

Pain

Describe your pain and/or dysfunction. _____

_____

_____

_____

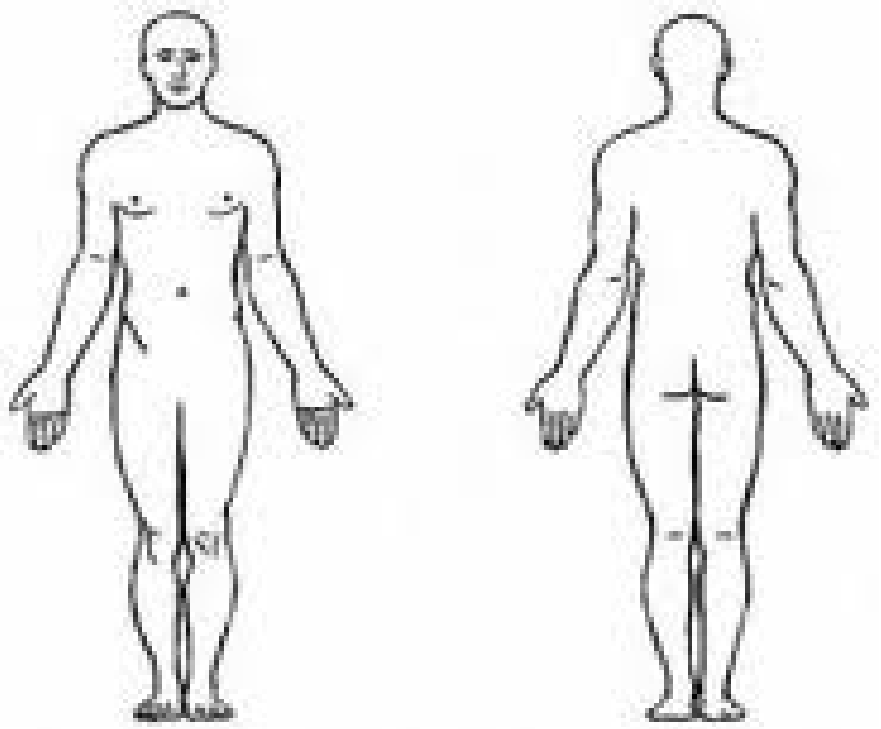
What do you think is causing it? _____

_____

What activity that you cannot do anymore because of pain would you like to be able to do again?

_____

Mark below where you experience pain/dysfunction:



CONSENT FOR EVALUATION AND TREATMENT

I, (please **print** your name)_____, understand that the treatments given at Adams Myotherapy & Massage are for the purpose of relief from musculo-skeletal pain, tension and/or spasm, stress reduction, and improved energy flow. I understand that Brynn A. Adams does not diagnose or treat illness, disease, or any other physical or mental disorder.

Myofascial Trigger Point Therapy includes: manual trigger point therapy, myofascial stretching, corrective exercises, ergonomic and self-care training.

It has been made clear to me that this therapy (myofascial trigger point/massage) is not a substitute for medical examination and/or diagnosis and it is recommended that I see a physician for medical conditions revealed on the Medical History Form or any other physical ailments I may have. I have stated all of my medical conditions and symptoms on the Medical History Form and take it upon myself to keep Brynn A. Adams updated about my physical health.

Side effects from treatment may include bruising, muscle soreness, swelling or tenderness for a short time (usually no longer than 24-48 hours) after treatment. I understand that I can refuse treatment at any time.

I understand that all information shared with Brynn A. Adams is confidential and no information will be released without my written consent. Photographs or other images of me may be used for evaluation purposes and to keep a record of my care and treatment. These images will become part of my medical record and are strictly confidential.

I understand that all bodywork offered is strictly non-sexual and if, at any time during the session, I exhibit inappropriate and/or sexual behavior towards my therapist, the session will be terminated, and I will owe the full amount due.

I understand that certain conditions are contraindicated for bodywork (unless otherwise approved by the treating physician): Bacterial/viral infections (hepatitis, flu/fever, kidney or bladder infection, etc.), Infectious skin diseases (dermatitis, ringworm, toe/nail fungus, poison oak/ivy, etc.), Heart conditions (coronary artery disease, arteriosclerosis, embolism/thrombus, aneurysm, high/low blood pressure, etc.), and Others (impairment from alcohol/medication, varicose veins, etc.).

I understand that I am responsible for all charges incurred, regardless of my insurance status and I agree to pay for services as I incur the charges. I understand and agree that appointments cancelled with less than 24 hours notice will be charged the full hourly rate.

By voluntarily signing below, I consent to treatment. I have been told about the risks and benefits of trigger point and/or massage therapy and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment from Brynn A. Adams at Adams Myotherapy & Massage.

Patient Signature_____

Date_____/_____/_____