

Myofascial Pain Treatment Center

1275 Main Street
Waltham, MA 02451
781-894-9430

Registration Form

Name _____

Address _____

Phone home (____) _____ OK to leave message
work (____) _____ OK to leave message
mobile (____) _____ OK to leave message

e-mail _____ OK to contact me and send
information

Date of Birth _____ Current Age _____

Occupation _____

Employer _____

Primary Care Physician _____

Referred by _____

Spouse/Partner _____

In case of emergency contact _____ at (____) _____

Signature _____ Date ____ / ____ / ____

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 Arrhythmia _____ |
| 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 beverage per day.
- I drink _____ alcoholic beverages per day.
- I drink _____ glasses of fluid 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 video game or computer games/web surfing.

I commute _____ minutes/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 currently or have recently taken:

Medication	Effects
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_____	_____
_____	_____
_____	_____

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

Supplement	Effects
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_____	_____
_____	_____
_____	_____

Patient Signature: _____

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CONSENT FOR EVALUATION AND TREATMENT

I, _____, understand that the treatments given at Myofascial Pain Treatment Center are for the purpose of relief from musculo-skeletal pain, tension and/ or spasm. I understand that Erika Bourne, RN does not diagnose 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 myofascial therapy 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 Erika Bourne, RN 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 Erika Bourne, RN 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 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 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 Erika Bourne, RN.

Patient Signature _____ Date ____/____/____