

**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 Curves?    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. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

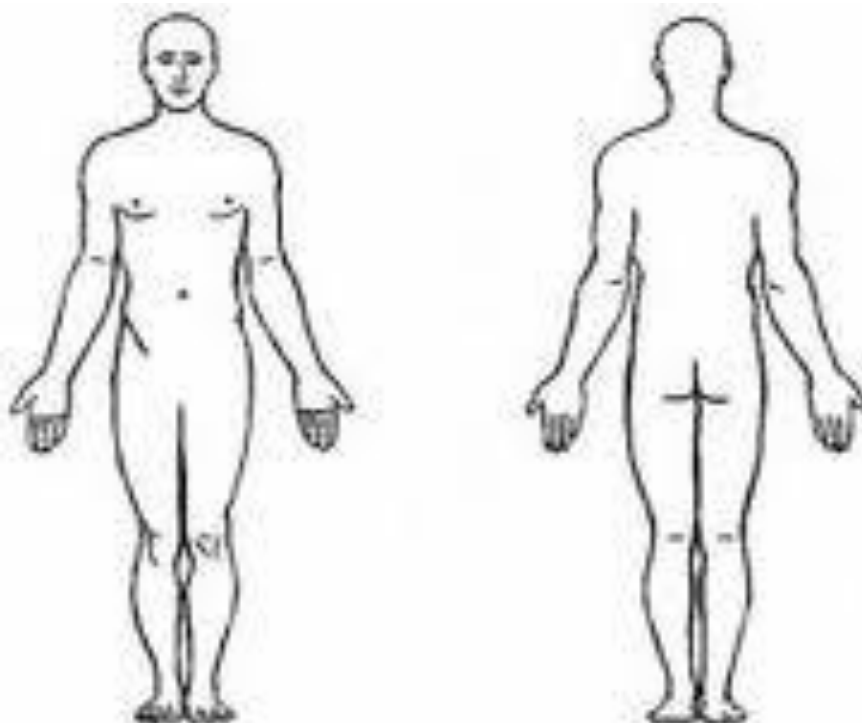
What do you think is causing it? \_\_\_\_\_

\_\_\_\_\_

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 \_\_\_\_/\_\_\_\_/\_\_\_\_