Neuromuscular Therapy ● Confidential Client Information

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Back/Hip Pain Severity Intake Form

Name_____**Home #**_____

Address_____**Cell #**_____

City _____**State**_____**Zip**_____**Date of Birth (month/day)**_____

Email_____**Sex**_____**Occupation**_____**Referred by**_____

Primary reason for visit_____

Specific goals you hope to achieve coming here _____

How long have you had your back pain_____

How did your back pain arise_____

Are there any specific activities which aggravate your back pain or discomfort_____

Does your back pain keep you awake at night_____

Describe the nature of pain. Sharp, dull, burning, aching, diffuse, electrical, etc._____

What have you tried, present and past, for your condition_____

Any MRI's/X-Rays/Bones Scans, etc...Describe results_____

Was it successful and did it help at all...Describe_____

Are you taking medications_____**Describe**_____

Are there any side-effects to your medication you're aware of_____**Describe**_____

Do you have any shooting pain, numbness, or tingling down your hips or legs_____**Describe**_____

Is your condition affecting/limiting ANY activities or exercise/sports _____

Have you ever had this or a similar condition before. If so, how was it resolved_____

Have you noticed your posture affected by your condition_____

How many hours do you sit each day?_____

What concerns you the most about your condition (your biggest fear)_____

What aspect of your life are you missing most and is most affected by your condition...i.e. sports, work, sex, daily activities, family, picking up your kids, etc._____

What do you hope will happen once you successfully complete treatment_____

What will happen to you if I can't help, your problem isn't solved, or I don't accept you for treatment_____
_____

Please check any of the following which apply to you, past or present:

__accident	__blood disorder	__cancer	__breast augmentation
__whiplash	__disc disorder	__heart attack	__broken bones
__neck pain	__low back pain	__seizures	__high blood pressure/cholesterol
__surgery	__abdominal pain	__headaches	__varicose veins
__bursitis	__carpal tunnel syndrome	__diabetes	__joint aches/arthritis
__HIV/Aids	__strains/sprain	__hepatitis	__decreased range of motion
__dizziness	__decreased strength	__pregnant	__other

Please explain any checks in the space below with approximate date of each occurrence:

_____
_____

Please read the following and sign below:

I, _____understand that Neuromuscular Massage Therapy (NMT) given here is for the purpose of muscular spasm/tension relief related to soft-tissue dysfunction. I _____understand the treating therapist does not prescribe medical treatment, diagnose illness, disease or any other physical or mental disorder. I have been made aware that NMT is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have. Because the treating therapist must be aware of existing condition, I have stated all my known medical conditions and take it upon myself to keep the treating therapist updated on my physical health. I understand that regardless of insurance reimbursements I am ultimately responsible for full payment of my account and payment is due at the time services are rendered. I understand that there is a 24 hour cancellation policy, and there will be a charge for late cancellation.

Signature _____ Date _____

Back Pain Specific 57 Questions:

Name:_____

Do You Have ANY Of These Back Pain SYMPTOMS? Please Check ALL That Apply And Describe When Necessary:

- □ Restrictions/pain bending, twisting, moving forward, backwards, sideways_____
- □ Pain in abdomen, down into buttocks, hips, low back, or around sacroiliac joint at base of spine_____
- □ Tailbone tender, kidney distress, rib inflammation, disk problems_____
- □ Coughing or sneezing brings sharp pain_____
- □ Can't turn in bed or lie on painful side_____
- □ Symptoms of sciatica (in buttocks & down leg)_____
- □ Pain in groin or down front of thigh/leg_____
- □ Do you constantly change positions while sitting due to general aching and burning in buttocks_____
- □ Difficulty getting up out of chair or even limp_____
- □ Can't bend over and touch toes_____
- □ Pain blamed on bursitis of the hip, compressed disk, arthritis of spine, sciatica, or sprung sacroiliac joint_____
- □ Pain down back or side of thigh and lower leg as far as the ankle_____
- □ Walking painful_____
- □ Getting up out of chair is painful_____
- □ Do you limp to favor the afflicted side or difficulty crossing your legs_____
- □ Rolling over on your "bad side" can awaken you at night_____
- □ Does lying down brings little or no relief to your pain_____
- □ Sense of swelling in the buttocks, leg, calf, or foot_____
- □ Impotence or pain in groin, genitals, or rectal area (FYI: Piriformis muscle)_____
- □ Atrophy of your butt muscles (gluteals)_____
- □ Sit-ups impossible_____
- □ Crawling on your hands and knees b/c pain is so bad_____
- □ Low back pain with stiffness in your hips or groin in the morning and trouble standing up straight_____
- □ Walk with feet turned out_____
- □ Pain in your bladder, urethra, rectum, tailbone_____
- □ Painful bowel movements (FYI: Intrapelvic muscle T.P.s)_____

Please Check ANY Of These Possible CAUSES For Your Back/Hip Pain And Describe When Necessary:

- □ Slouch often, stooped posture or habitual leaning to one side_____
- □ Sit often with knees up_____
- □ Read with a book in my lap or flat on a desk_____
- □ Computer screen low_____
- □ Trouble with my feet_____
- □ Picking up something too heavy_____
- □ Maintaining any twisted or unbalanced position (i.e. at computer)_____
- □ Whiplash_____
- □ Prolonged sitting/standing or staying in strained position too long_____
- □ Repetitive motion at my job_____
- □ Stretching too far overhead when cold_____
- □ Overstretching, too much twisting or bending at work, etc._____
- □ Sagging mattress_____
- □ One leg is shorter, I have short arms, or one side of my pelvis is smaller_____
- □ Recent sudden falls, catching myself to keep from falling, or auto accidents_____
- □ Lifting something and twisting off balance_____
- □ Climbing or unaccustomed gym exercise_____
- □ Sitting on hard surfaces or just sitting too much_____
- □ Are you pregnant? Recently pregnant? Hysterectomy, Pelvic Surgery?_____
- □ Weight lifting, running, falls, aerobic exercise, or habitually bearing your weight on one side of your body (i.e. carrying your child always on same hip)_____
- □ Standing or sitting still for long periods of time_____
- □ Do you sit with legs crossed, especially always crossing same leg_____
- □ Do you sit on your wallet_____
- □ Sports activities, running or walking too much_____
- □ Limping to favor bad knee or sore foot_____
- □ Changing direction quickly in your sports/activities (tennis, handball, soccer, football, basketball, volleyball, etc)_____
- □ Any sit-ups, leg-ups, or other abdominal exercise_____
- □ Bucket seats in your car_____
- □ Strenuous or intense sexual activity_____
- □ Habitually slouching in chair and sitting back on the tailbone_____
- □ Chronic pelvic infections, endometritis, intrapelvic cysts, fibroids, surgical scarring, and hemorrhoids (FYI: promotes intrapelvic T.P.'s)_____