WELCOME TO MYO PAIN CENTER aka Talking Hands Massage

You have been referred to us by your physical therapist, doctor, friend or internet. We do our best to provide the professional services you seek and deserve to become pain free. All treatments take place in a safe and ethical space

What to expect on your first visit?

Your first appointment consists of reviewing patient history form, postural evaluation, pain mapping, range of motion assessment and trigger point therapy. During the intake interview you can ask questions, discuss your general concerns and expectations, go over policy, determine the course of the treatment, setting goals, designing a treatment and self-care plan, and getting to know each other. All new patients bring the following to their first appointment.

Read, complete and bring Patient-History to your first appointment

Bring copies of other useful documents such as X-rays, reports or MRI

Bring comfortable underclothes such as a bathing suit, shorts or running pants for evaluation, assessment and treatment.

If possible a doctor's prescription or referral with diagnosis

If you have any questions please feel free to ask. I am looking forward to work with you.

Sincerely,

Carlos Messerschmidt, LMT, CMTPT, NCTMB

Patient- History **(please print clearly - all information is confidential)** Date: _____

Name:_____ Phone (H)_____(W)_____

Cellphone_____Email_____

Adress:_____

City:_____ State _____ Zip code: _____

Contact person in case of emergency: _____Phone: _____

How did you hear about MPC OC? _____

Your: Height _____ Weight _____ □ Right handed □ Left handed Age____ Birth date_____

RELATIONSHIP: Married □ Divorced □ widowed □ single □ separated □ partner □?
Do you have children? Yes / No How many? 1 2 3 4 5 Age(s) _____

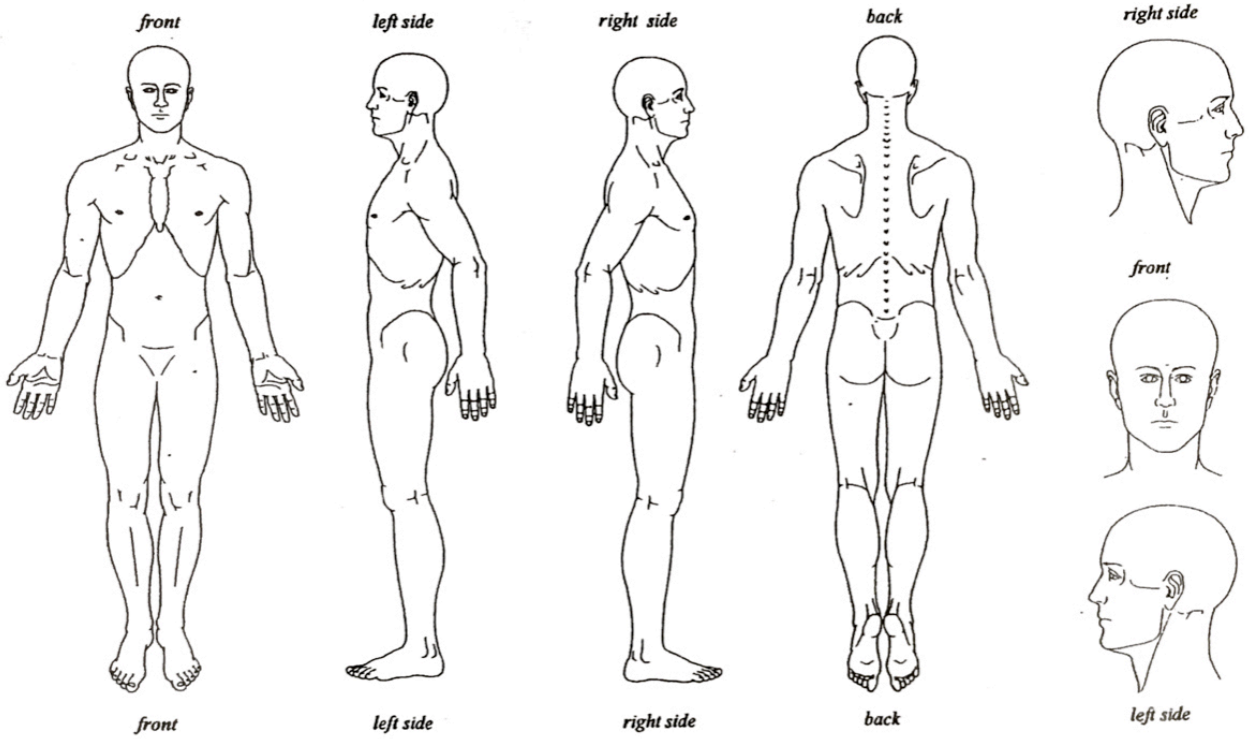
VOCATION:

What is your occupation? ……
……..
Please list your job duties / activities at work. ……
……

PAIN-INJURY-SYMPTOMS

What are you unable to do because of pain that you want to do? (Regain function) ……
……
……
What are your mayor symptoms? Please describe. …….
……
……
..……
When did you first notice your pain /symptoms? ……..
Describe event that started the pain. ……..
……
How did the pain start? ___ suddenly, ____ gradually or ____ other …….
……
What action (s) increases your pain? …..…….....
……
Please circle appropriate words that make your symptoms feel better:
□ Ice □ Heat □ Rest □ Stretching □ Exercise □ Medication □ Therapy (what kind)
……
Have the symptoms affected your personal life? ……...
……..
……..

Please indicate on the drawing below where your pain is **today** with corresponding pain numbers. Use lines pointing to specific regions to separate pain levels and sensations in different areas and numbers accordingly. Feel free to add any descriptive words specific to any region. For example, your shoulder blades could be a 6/10 and "burning" while your front of shoulders are 3/10 and "aching"



1. Please place an "X" in the table below at a point that best corresponds to the general intensity of your overall pain.

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

No pain **Moderate pain** **worst pain**

2. Please place an "X" in the table below at a point that best corresponds to the general degree of dysfunction due to your pain.

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

No dysfunction **Moderate dysfunction** **worst dysfunction**

How long have you had the pain at the present level? **……...**

MYO PAIN CENTER OC
Carlos Messerschmidt CMT, CMTPT, NCTMB
170 E 17th Street, Suite 211 Costa Mesa, CA 92627 Phone 949-413-1567

PREVIOUS TREATMENT FOR PAIN

Please list doctors and /or health care providers you have seen concerning this pain, injury or symptoms?

Name : Physician / Therapist	Street, City , Zip Code	Phone #

Therapy: □ Chiropractic □ Biofeedback □ Acupuncture □ Physical Therapy □ Massage
□ Psychiatrist □ Psychotherapy □ Feldenkrais □ Alexander Tech. □ others

How often are appointments? 1 2 3 times per week or 1 2 3 4 per month past / current

Please list all medications you are taking, the dosage, reason for taking and the date started:

Name Medication	Reason	Dosage / mg	started	Ended

DIAGNOSTIC TESTS

Have you had any diagnostic test, such as □ X-rays □ MRI □ CT-Scan □ EMG □ Bone scan?

MEDICAL CONDIDITONS involving**:**

□ Heart □ Lungs □ Liver □ Kidney □ Digestive system □ Infection □ High Blood Pressure
□ Thyroid □ Cancer □ Others (use lines below to explain) ……
……
……
Have you been told by a physician that your have the following:

□ Herniated or bulging disks □ Spinal Stenosis □ Bulging disk □ Thyroid problems □ Scoliosis □ Diabetes

DATES OF ACCIDENT/SURGERY **ACCIDENT/SURGERY/ SIGNIFICANT TRAUMA**

…… ……..
…… ……
…… ……
…… ……
…… ……

Do you know, or did you as a child, prefer to sit on one leg? Yes /No
Do you currently wear shoe orthotics? Yes / N o
If yes, how long have you been wearing them? ……

COMPUTER RELATED WORK

Does your job require you to reach above, below or at shoulder level ? YES / NO
Are you required to use your hands for: □ fine manipulation □ grasping □ pushing □ pulling? YES / NO
Can you perform your normal work duties? YES / NO
Have you missed work or been placed on modified duty from this injury? YES / NO
When and how long, were you placed on disability, and/or modified duty?
Normal number of hours worked per day: (circle) 2 4 6 8 10 12 , Per week: _____
How many breaks do you take? 1 2 3 , □ None . How much time per break? 5 10 15 minutes

If you use a computer, please check the type of equipment you have:
Ergonomic chair □ standard keyboard □ split keyboard □ other keyboard □ _____
Standard mouse □ voice-activation software □ other mouse □ (describe) _____
Standard phone □ phone headset □ laptop □ IPad □ data entry device

Have you modified your equipment since your pain / injury began? Yes / No If so, describe.
……

List the percentage of time you spend on an average day performing the following activities ***(out of 100%)***:

	5	**10**	**15**	**20**	**25**	**30**	**40**	**50**	**60**	**70**	**80**	**90**	**100**
Sitting													
Standing													
Walking													
Driving													
Lifting													
Reaching													
Writing													
Type/Keyboard													
Mouse													
Phone													
Other													

STRESS:

Are you under stress at □ WORK □ SCHOOL □ HOME □ OTHERS?
Has your work load increased in the past 3 / 6 / 9 / 12 month? How much? _____%
Do you consider your stress level to be □ LOW □ MODERATE □ HIGH?

Please describe what you do to alleviate your stress:……..
…….
……
Have you gained or lost weight since your pain began? How much 5 10 15 20 25 30 35 40 45

SLEEP

On average, how many hours do you sleep per night? 3 4 5 6 7 8 9 10 11 more
Does this feel like enough sleep for you? YES / NO

What type of bed do you sleep on? □ MATTRESS □ FUTON □ WATERBED

Is your bed comfortable? YES / NO □ HARD □ MEDIUM □ SOFT □ OLD
How many pillows do you use? 1 2 3 4 5

What position(s) do you sleep in? □ BACK □ STOMACH □ RIGHT SIDE □ LEFT SIDE
□ ARMS OVERHEAD □ FETAL POSITION □ PETS IN BED

Do you have trouble □ FALLING ASLEEP □ STAYING ASLEEP □ WAKING UP? YES / NO

What awakens you most often ? □ PAIN □ BUSY MIND □ THURST □ DREAMS
□ ANIMALS □ VOICES □ NOISE □ OTHERS

EXERCISE

Are you able to exercise? Yes / No
If yes, what type of exercise do you do and how frequently? Please describe. ……
……
……

When you exercise, does it □ HELP or □ AGGRAVATE your condition / symptoms?
Have you recently □ STOPPED or □ STARTED exercising?
Do you enjoy exercising? YES / NO
What kind of exercise do you think you would enjoy doing? ……..
……

DIET

What is you typical breakfast? ……
..……..
What is you typical lunch? …….
...…… .
……..
What is you typical dinner? ..……..
...…….
I smoke ___ □ cigarettes □ cigars □ pipes per day. □ I don't smoke.
Idrink ____ cups of □ coffee □ tea □ caffeinated soda per day
Idrink ____ alcoholic beverages (which? ……per day.
How much water do you drink per day? …….
Please list all vitamins, minerals and dietary supplements that you take: …….
……
……
Are you vegetarian? YES / NO (if yes please describe)
……..……
……....
……..
Do you have any food sensitivities? Yes /No (if yes, please describe) ……
…. ..……
……

MEDICAL INFORMATION

1. Do you ever experience: (please check and use **"C"** for current and **"P"** for past)

EARS: □ ringing □ pressure □ clicking □ ache □ blockages □ hearing loss
TEETH/JAW: □ grating □ clenching □ grinding □ popping □ hard to open □ locks to open
OTHER: □ fainting □ nervous tics □ nausea □ tinning □ vision changes □ others ……..

JAW/FASCIAL PAIN

Do you have TMJ? Yes / No
Do you have pain associated with chewing or yawning? Yes / No
Do you wear a night guard or mouth splint? Yes / No
When was your last eye exam?

How much time do you spend driving per day? ……..
……..

ASSOCIATED MEDICAL CONDITIONS

Are you aware of having (or have you been diagnosed as having) any of the following conditions? Please check which ones and indicate **"P"** for past and **"C"** for current.

1. □ Asthma □ allergies □ bronchitis □ emphysema □ hepatitis

2. □ Angina □ diabetes □ stroke □ phlebitis □ high blood pressure □ low blood pressure
   □ Varicose veins □ migraine headaches

3. □ Chronic constipation □ hemorrhoids □ severe diarrhea □ alcoholism □ drug abuse
   □ Thyroid disorders □ candidacies □ irritable bowel □ depression □ chronic fatigue
   □ Endometriosis □ eating disorders

4. □ dyslexia □ memory loss □ cancer □ seizures □ polio

5. □ Cancer □ scoliosis □ short leg □ arthritis □ osteoporosis □ Morton foot structure
   □ other ……

(Therapist use only) ……..
……..
……..
……..
……..
……..
……
……
……

BODY – MIND CONNECTION *(ANSWER THE FOLLOWING QUESTION ONLY IF DESIRED)*

Attached to the medical history sheet is a Body-Mind Connection questionnaire. This information can be very supportive for client or patient as well as for the practitioner to include and consider for future treatments and treatment plans. This Body-Mind questionnaire will not be release to any third person or institution**.** *(Circle one choice please or describe)*

1. How do you cope with pain? ……
……
……
2. How do you compensate for the pain and what are the results? ……
……
……
3. How does the pain effected your life? ……..
……
……
4. Are you friends with your body? YES NO
   If No, list body parts which disagree with you and why. ……
   ……
5. When you breathe, do you feel you breath fill your whole body? YES NO
   If NO, where do you feel your breath stop? ……..

6. Do you feel like you are struggling with anything / anyone? YES NO
   If YES, Explain briefly.……...
   ……

7. Where do you hold tension? (Circle one and describe what the tension feel like)
   □ Mental □ Emotional □ Physical? …….
   ……
8. In your own words, what is the cause of this tension? …….
   ……
9. What negative feeling are your aware of holding / expressing on a regular basis?
   Where do you think these feelings impact your body. ……..
   ……..
10. Do you trust your intuition? YES NO
    If YES, do you take action on your intuitive hunches? ……..
    ……
11. Do you put faith in higher power? YES NO
    If YES, where does this source of power reside?……

12. List aspects of your life that are stressful.
    □ Job □ relationships □ family □ health □ past trauma □ other

13. How much power do you have over yourself? *(Circle all that apply)*
    □ None at all □ some □ it changes □ I Don't care □ My power and I are one □ I don't understand

14. Have you gone through an intense process of growth, renewal or change recently? YES NO
    If YES, how has this experience left you*? (Feeling, burned out, excited, neutral, etc)* ……
    ……
    ……

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM.

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CLIENT / PATIENT POLICY

Welcome to MYO PAIN CENTER OC. The purpose of this statement is to determine what is and what is not acceptable, and to establish professional boundaries, so please read the following carefully.

You have been referred to me by a friend, healthcare professional or by your treating physician. My goal is to provide the highest quality care (Trigger Point Therapy and Massage Therapy) to those who seek professional service for the relief of chronic pain. We perform only those services for which we are qualified. My practice does require an initial intake interview and the completion of patient history form. More details you will find on page two under procedures.

BUSINESS HOURS: see Online Scheduler! **By appointment only.**

FEE SCHEDULE: (March 2018)

Initial interview *includes* preparation*, evaluation, and therapy*		
Standard intake interview	75 minutes	$145
Comprehensive intake interview	90 minutes	$165

Treatment times include 10 min for preparation and approx. 50/80 minutes for treatment.

Trigger Point Therapy	60 minutes	$125
	90 minutes	$165
Therapeutic Massages		
(Deep Tissue, Sports, massage cupping,	60 minutes	$125
Lymphatic treatments, or customized)	90 minutes	$165
Swedish massage (Relaxation)	60 minutes	$115
	90 minutes	$155
Rosen Method Bodywork	60 minutes	$105
Rosen Method Movement	60 minutes	$15
Discount Cards for prepaid sessions		
Buy 5 sessions get one for free	60 minutes	$625
Buy 10 sessions get two for free	60 minutes	$1125
Buy 5 sessions get one for free	90 minutes	$825

Stricter rules under the Telephone Consumer Protection Act (TCPA go into effect on Oct.16 2013. Myo Pain Center OC now must get permission in writing to send automated text messages to clients, even if you have an established business relationship.
I, …….. agree to receive text messages to this mobile phone numbers ( ) _____-_____ reminding me about my upcoming appointments with Myo Pain Center OC. I understand that SMS reminders are optional and that messages and Data rates may apply.
Please initial here: _____

PAYMENT:
The payment for all type of treatment is due at the time of service and can be paid by check, Visa/Master card or cash. A fee of $25 will be charged for returned checks.

CLIENT / PATIENT POLICY continues

REFUNDS: Massage cards and gift certificates are non-refundable, but you can transfer to someone you know or share it.

CANCELLATION POLICY :
If you are a cash patient, please notify us at least 24 hours prior to the appointment time to avoid a cancellation charge. A cancellation fee equal to 100 % of the scheduled service fee will be charged if a timely notice of cancellation is not received.

If you are a Workers Compensation patient, please notify us at least 24 hours in advance if you need to cancel your appointment. Missed appointments without 24 hours' notice for Workers Compensation patients will be reported to the treating physician and insurance company as patient non-compliance which could possibly jeopardize your right to therapy. A proper cancellation gives others in need the opportunity to be treated.

CONFIDENTIALITY:
Confidentiality is used to protect client and patient information. If it becomes necessary to share information about one's care with other professionals involved in their care or insurance companies paying the bill, my practice is required to attain permission to release medical information. Information about care and treatments are shared only if the client or patient signs a statement authorizing it.

IMPORTANT INFORMATION:
Pregnant women and individuals with high blood pressure, heart conditions, or under medical care should consult a physician before scheduling a session.

PROCEDURES:
MPCOC offers a variety of services; therefore two types of initial intake interviews have been developed. They are different in duration and the initial evaluation/physical assessment is part of your first appointment. The ***standard intake interview*** is designed for a regular client who seeks treatment for acute symptoms, relaxation, nourishment, or stress reduction (75 min). Massage Therapy would be the modality to meet those needs. Symptoms are mild and usually tightness, stiffness or aching pain.

The ***comprehensive intake interview*** (90 min) is used with acute and chronic pain patients, Worker's Compensation patients, and individuals with injuries who primarily seek treatment for pain relief. Trigger Point therapy is best suited for these problems. For those individuals a medical history sheet and a different evaluation need to be completed and the best approach in treatment has to be determined. Symptoms are dull ache, sharp pain, soreness, tingling, numbness, cold fingers or feeds, etc.

I have completed this health form to the best of my knowledge. I understand that the Myo Pain Center OC (MPCOC) and the Lymphatic Manual technique services are a therapeutic health aid and do not take the place of a physician's care when indicated. The MPCOC is not involved on the diagnosis or cure of any disease whatsoever. The therapeutic methods being used by MPCOC are used only in the context of rehabilitation or for the beautification of the body.

I have read and understand the "Client/Patient Policy". Please initial here_____

Patient / Client signature _____Date_____

Therapist signature _____Date_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

My office / practice is required to have permission to send progress reports to your doctor (s), other therapist (s) and your insurance company. Please sign your initials in the appropriate slots to grant it.
Thank you.

I hereby give permission for Carlos Messerschmidt to send a progress report to my physician:_____

I hereby give permission for Carlos Messerschmidt to send a progress report to my therapist: _____

I hereby give permission for Carlos Messerschmidt to send a progress report to my insurance:_____

I agree that all information contained in this medical history is true and complete:

Patient signature _____Date_____

Therapist's signature _____Date_____

CONSENT FOR EVALUATION AND TREATMENT

I, _____, understand that the treatments are given at MPC OC are for the purpose of relief from musculo-skeletal pain, tension and/ or spasm.

I understand that Carlos Messerschmidt LMT, CMTPT 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 Carlos Messerschmidt LMT, CMTPT 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.

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 Carlos Messerschmidt LMT, CMTPT.

I have read CLIENT / PATIENT POLICY above and understand it.

Patient Signature_____ Date____/_____/_____