

Chronic Low Back Pain and Primary Health Care

Client ID		Month	Day	Year
<input type="text"/>				

LMT Patient Intake Form

Primary Complaint / Cause of Injury

Overall Medical History (Including Accidents, Injuries, and Surgeries)

Previous Treatments and Results

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Lifestyle Questions

Pain progression through the day: _____

Sleeping position/Disturbance _____

Activities that increase pain _____

Activities that decrease pain _____

Check all current conditions that apply:

<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Sciatica R or L	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Depression	<input type="checkbox"/> Headaches	<input type="checkbox"/> TMJ	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Disk Problems	<input type="checkbox"/> Constipation/Bowel Problems	
<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Allergies	

Using the line below, mark how suitable a candidate for this type of massage is this patient?

Not at all suitable Extremely Suitable

How much improvement do you expect this patient to experience in 10 weeks?

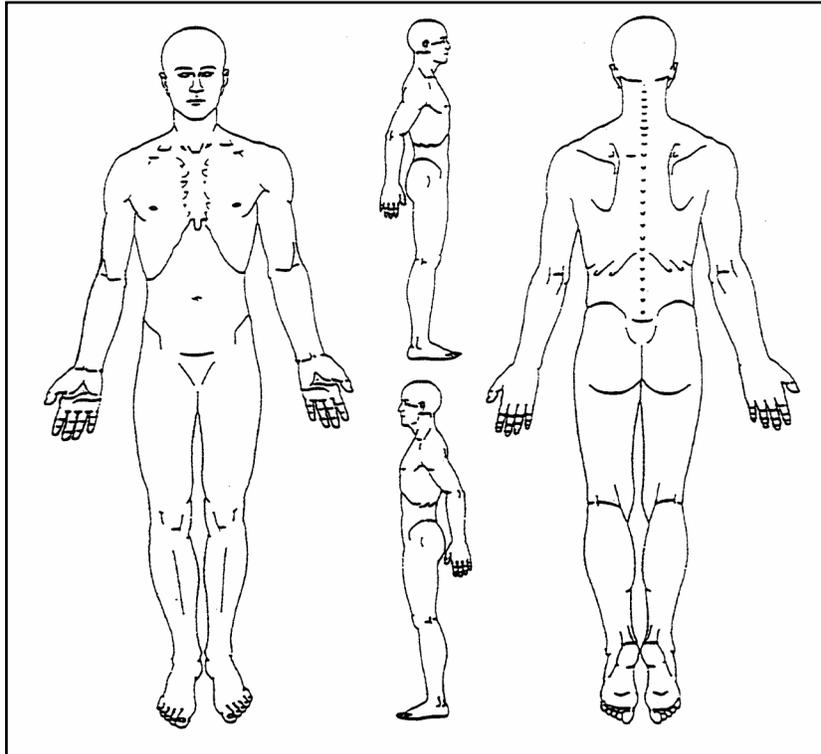
No Improvement Complete Recovery

Chronic Low Back Pain and Primary Health Care

Client ID: - -

Month: / Day: / Year:

Provider Initials: _____ Visit #: _____ Visit Length: 75 Minutes*
 60 Minutes*
 50 Minutes with self-care education*



Patient Update / New Concerns Since Previous Visit

***All visits must include at least 50 minutes of table-work.**

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Assessments Performed During This Visit:

Standing Postural Assessment (Mark [X] appropriate description for each sub-item below)

1. Feet Alignment

a. Subject Left: Parallel Rotated Laterally Rotated Medially

b. Subject Right: Parallel Rotated Laterally Rotated Medially

2. Iliac Crest Alignment: Subject Left High Even Subject Right High

3. Shoulder Alignment: Subject Left High Even Subject Right High

Therapies Provided at this Visit (Mark [X] all that apply):

Trigger Point Therapy (Including, but not limited to the following)

- | | | | |
|---------------|----------------|-----------------------|-------------------|
| - Glut Medius | - Glut Minimus | - Quadratus Luumborum | - Spinal Erectors |
| - Psoas | - Piriformis | - Tensor Fascia Latae | - IT Band |

Active Isolated Stretching ***OR*** Stretching (Including, but not limited to the following)

- | | | |
|-----------------|----------------------|--------------|
| - Hamstrings | - Quadratus Lumborum | - Quadriceps |
| - Psoas/Iliacus | - Gluteals | - Piriformis |

Myofascial Techniques (Including, but not limited to the following)

- | | | |
|------------------------------------|------------------------------|------------------------------|
| - Skin Rolling | - Sacral Decompression | - Fascial Unwinding |
| - Pin and Stretch | - Muscle Stripping | - Horizontal Erector Release |
| - Horizontal Thoracolumbar Release | - Thoracic Diaphragm Release | - Pelvic Diaphragm Release |

Neuromuscular Techniques (Including, but not limited to the following)

- | | | |
|------------------------|------------------------------|-----------------|
| - Cross Fiber Friction | - Origin Insertion Technique | - PNF Technique |
|------------------------|------------------------------|-----------------|

CranioSacral Therapy (Including, but not limited to the following)

- | | | |
|---------------------------|--------------------------------------|----------------------------|
| - Occipital Atlas Release | - Thoracic Diaphragm Release | - Pelvic Diaphragm Release |
| - L5 S1 Decompression | - Dural Mobilization Sacral Traction | |

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Therapies Provided at this Visit (cont'd) (Mark [X] all that apply):

<input type="checkbox"/>	Lymphatic Drainage
<input type="checkbox"/>	Rocking and Jostling
<input type="checkbox"/>	Deep Tissue Therapy
<input type="checkbox"/>	Other: _____

Massage Positioning at any visits:	Visits 6-10 only:
<input type="checkbox"/> Sidelying	<input type="checkbox"/> Prone w/pillow supporting low back
<input type="checkbox"/> Supine	
<input type="checkbox"/> Seated	

Take Home Exercises (Mark [X] all that apply):

<input type="checkbox"/>	Low Back Resting Position with breathing
<input type="checkbox"/>	Piriformis Stretch
<input type="checkbox"/>	Quadriceps Stretch
<input type="checkbox"/>	Walking to help lower back
<input type="checkbox"/>	Psoas Stretch
<input type="checkbox"/>	Hamstring Stretch
<input type="checkbox"/>	Trigger Point Ball

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□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□
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Notes:

Did treatment protocol keep you from doing anything today that you feel would have significantly improved the effectiveness of your treatment today? (eg., referrals to other providers, treatments disallowed by protocol)?

Yes No

If yes, please explain:
