Neuromuscular Wellness
Advanced Medical Acupuncture
57465 N. Main St.
Three Rivers, MI 49093
574-612-3068

We are a Holistic Based Provider of several Alternative Therapies for Acute and Chronic Pain and other conditions. We believe the body was created with the natural ability to heal itself. For what it cannot heal itself, God provided natural remedies to aid the body towards health.

Symptoms are a way of telling us our body is not functioning properly. Though symptoms are important in the aspect that they can tell us where the pain is, the goal is to resolve the root problem. Intake forms are vital to proper modality choices. They help us assess your current and past health information. They tell us what medications you're on, and the conditions that have and currently been present. Most of these questions are just a matter of clicking a radio or check box. There are some that require that you type a response. We have done our utmost to make the form as easy and quick as possible.

The current Practitioners offering services are Adam Trisler and Brian Johansen. Some modalities are offered by both, and each practitioner has specialties that are specific to them.

Adam Trisler C.H.H.P., S.M.T., C.M.T., P.Ac.
Michigan Medical Acupuncture Association Vice President

Brian Johansen C.H.H.P., C.R.M.T., C.M.T., P.Ac
Michigan Medical Acupuncture Association Board Member
Certified Reiki Master (C.R.M.)

Joint Services

Practical Acupuncture (P.Ac), | Cold Laser Therapy,
Advanced Reflexology (Micro-current Stimulation),
Acupressure | Skin Friction | Dietary Counseling | Mobilization Therapy,
Heat Therapy | Shiatsu Massage | Herbal Medicine | Manual Therapy
Tui Na | Massage Therapy. (C.M.T) | Hot Stone Therapy | Reflexology (CR)

Specialized Services

Brian Johansen

Reiki (Healing Energy Therapy)

Adam Trisler

Transcutaneous Electrical Nerve Stimulation,
MPS Therapy. Scandinavian Mobilization Therapy (S.M.T)

Chronic pain is not something that can be remedied in a single visit.
To alleviate the pain and correct issues of a Chronic condition will require several visits. Though correcting a long-term condition does take time, it is always our goal to resolve the root problems as proficiently as possible. In most cases some relief from the pain is felt after the first session, and with each session condition improves.

We want to thank you for taking the time to fill in your intake form through our website. It saves both us and you time that is better spent on addressing your conditions.

Please fill out your form then save it to your device with your first and last name.
Then email it to nmwellness@comcast.net

If you have questions or would like to talk to us about an appointment, please feel free to call. If we are busy and unable to answer the phone, be sure to leave a message with your name and number and we will call you as soon as possible. Calls without a message will not be returned due to the high volume of telemarketing calls we receive.

Best Regards,
Adam Trisler S.M.T., C.M.T., C.H.H.P., P.Ac.
MMAA Vice President
Brian Johansen C.H.H.P., C.R.M.T., C.M.T., P.Ac
Certified Reiki Master
MMAA Board Member

CLIENT INTAKE FORM

* FEILDS MARKED WITH A RED ASTERIC ARE REQUIRED FEILDS

*NAME: SEX: MALE FEMALE

*ADRESS: CITY STATE ZIP:

*HOME PHONE: WORK PHONE: *CELL PHONE:

* BIRTH DATE: HEIGHT: WEIGHT:

EMAIL:

Providing your email allows us to communicate medical information to you.
It will not be shared, sold, or misused.
We ask for a cell phone for the convenience of easy text communications

OCCUPATION:

* PRIMARY CARE PROVIDER: * PROVIDERS ADDRESS:

CITY: STATE: ZIP: * PHONE: EXT:

* PERMISSION TO CONSULT WITH PRIMARY CARE PROVIDER YES: NO:

I, do hereby authorize Adam Trisler, and any of his agents, to acquire from and/or release information to my healthcare provider

* In Case of Emergency, Please Notify:

Name: Phone: Relationship:

Reason for Appointment:

Describe Symptoms:

Symptoms began:

How frequent:

Duration of symptoms:

Did someone refer us to you? YES NO Name:

* Patient/Guardian Signature * Date

CHEIF COMPLAINT

Present symptoms: List areas of pain in order of Severity

Chief: Began (Mo/Yr.)

Intensity of pain 0 1 2 3 4 5 6 7 8 9 10

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Intensity of pain 0 1 2 3 4 5 6 7 8 9 10

Is the condition related to: Occupation Car Accident Work Accident Fall Sports Injury

Explain

If none of the above what started the condition?

Are you taking medication for this condition? Yes No

If so, What medications?

Have you seen a health care professional for this condition? Yes No

Did the condition come on rapidly? Yes No

Has the condition been present for more than a month? Yes No

Has the condition occurred before? Yes No

When is the pain worse? Morning Midday Evening All day

What aggravates the condition?

What alleviates the condition? (ex: heat, ice, pressure applied, etc.)

Is this condition getting progressively worse? Yes No

Does this condition interfere with work? Sleep? Daily Routine?

Dose the condition cause you anxiety, stress, and/or depression? Yes No

Is the pain: Dull Sharp Stabbing Aching Is the pain: Fixed Moving

Other:

Please describe any other symptoms that accompany your pain:

Have you had any advanced test performed for this? Yes No

(X-Rays, CT, MRI, Nerve Conduction Study, Ultrasound, etc.)

If yes: Date:

Type:

Health History

Check the following conditions that apply to you, past and present. Please feel free to add your comments to clarify any conditions on the following page.

Musculoskeletal
- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendinitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease
- Other: Please clarify below

Circulatory and Respiratory
- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Swollen ankles
- Pressure sores
- Varicose veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Sinus problems
- Asthma
- High blood pressure
- Low blood pressure
- Lymphedema
- Other: Please clarify below

Skin
- Rashes
- Allergies
- Athlete's Foot
- Warts
- Moles
- Acne
- Cosmetic surgery
- Other: (Please clarify below

Digestive
- Nervous stomach
- Indigestion
- Constipation
- Intestinal gas/bloating
- Diarrhea
- Diverticulitis
- Irritable bowel syndrome
- Crohn's Disease
- Colitis
- Adaptive aids
- Other: Please clarify below

Nervous System
- Numbness/tingling
- Twitching of face
- Fatigue
- Chronic pain
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/shingles
- Cerebral Palsy
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's disease
- Spinal cord injury
- Other: Please clarify below

Reproductive System
- Pregnancy:
  - Current
  - Previous
- PMS
- Menopause
- Pelvic Inflammatory Disease
- Endometriosis
- Hysterectomy
- Fertility concerns
- Prostate problems

Other
- Loss of appetite
- Forgetfulness
- Confusion
- Depression
- Stress, or other strong Emotions
- Difficulty concentrating
- Drug use (Please clarify below
- Alcohol use / How often
- Nicotine use / Packs per day
- Caffeine use / Amount
- Hearing issues
- Visual Issues
- Burning upon urination
- Bladder infection
- Eating disorder

Disorders/Implants
- Diabetes
- Fibromyalgia
- Post/Polio Syndrome
- Cancer
- Infectious disease (List Below)
- Surgeries (List Below)
- Other: (List Below)
- Pacemaker or any other device that was implanted by a physician
- HIV/AIDS Positive
- Hepatitis
- Bleeding Disorders

Please Clarify any "Other" choices:

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the Practitioner of any changes in my status.

*Client's Signature: ______________________________ Date: ______________

Please explain any infectious Conditions or Diseases you have.

Are you currently under a doctor's care for diagnosed conditions? YES NO

If yes please list your conditions.

If you have had surgeries or implants please list here

Are you allergic to any medications, or experience allergic reactions to; herbs, or essential oils? YES NO

Please list.

Where do you usually work? Indoors Outdoors

Are there occupational stressors (chemical, physical, psychological, etc.)? YES NO

If yes, Explain

Do you exercise regularly? YES NO Type/Frequency:

When is your usual Bed time?: How many hours do you generally sleep?

Do you experience disturbed sleep? YES NO

If yes, Explain

How much water do you drink daily?

Your diet can have a large impact on muscle tension and degeneration, and the severity of inflammation in the body. The purpose of these questions is to better understand how much nutrient content the body is receiving.

It also helps us in making suggestion of what types of food would be beneficial to add to your diet.

	Fast Foods	Resturants	Fresh Foods	Junk Foods	Sweets
Morning/Breakfast:					
Afternoon/Lunch:					
Evening/Dinner:					
Snacks:					

What types of food are the most consumed?

Sweet Spicy Sour Pungent (sharp/strong) Salty

What food types are the least consumed?

Sweet Spicy Sour Pungent (sharp/strong) Salty

PAIN LOCATION CHART

This section is to record the areas of pain that you are experiencing. There is also a "Other" section in the key to identify any scars, bruises, wounds, and varicose veins in the area of pain. These are important to identify as each requires different treatment types. The section on recording Pain location shows the format for recording and how to fill each section out. This is followed by an example to refer to. The two following pages are the front and back of the body with a maximum of five areas of PAIN or "OTHERS" to identify.

ABBREVIATION KEY

PAIN TYPE:

A – Aching P – Pain SP – Severe SB – Stabbing B – Burning S – Soreness ST – Stiffness
PN – Pins & Needles N-Numbness T – Tingling TD - Tender

OTHER: S - Scars B - Bruises W - Wounds V - Varicose Veins

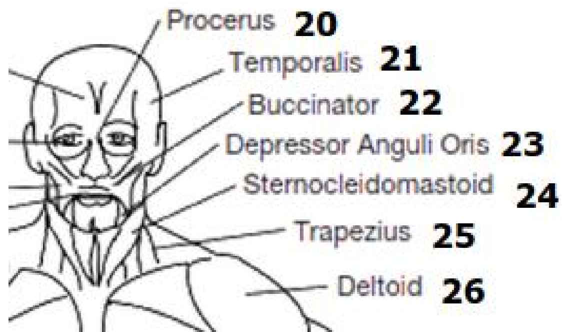
Recording Pain Location Information

Area: L | R Other Major | Secondary Fixed | Moving

Pain / Type: | | | | Intensity:

Comments:

Area - Locate the number that is closest to where you are having problems record the number
L | R – Indicate if it is on the Left Side or Right by choosing one
Other – Found in the Abbreviation Key for scars, varicose veins, etc. These are important so list them if they are in the area of pain. Click the "Other" button and the "Type" button in "Pain / Type"
Major | Secondary – Is the problem a major "prevalent" problem or secondary. Choose one.
Fixed | Moving – *Fixed* pain is pain only in that area – *Moving* means it seems to move around. Choose one
Pain / Type – Click "Pain" (*type indicates you are recording an "Other"*). Use the Abbreviation Key to record up to 4 pains symptoms using the *Letter Designations*.
Intensity – Using a scale of 0-10 supply a number that reflects the intensity of pain
Comments – This is to specify if an area is associated with another recorded area of pain OR to add any information you feel is needed



Example:

***This example shows one area to give you an example of how to fill the form out. You do not have to focus on one area, you can record up to 5 separate areas.*

Let's say you are having shoulder pain.
It is on both sides, but one side is more pronounced in pain then the other. They both have pain in different areas.
There is scar tissue in the pain area that is from a past injury, but there is no pain associated with the scar.
Your information would look like this.

Area: L | R Other Major | Secondary Fixed | Moving

Pain / Type: | | | | Intensity:

Comments:

Area: L | R Other Major | Secondary Fixed | Moving

Pain / Type: | | | | Intensity:

Comments:

Area: L | R Other Major | Secondary Fixed | Moving

Pain / Type: | | | | Intensity:

Comments:

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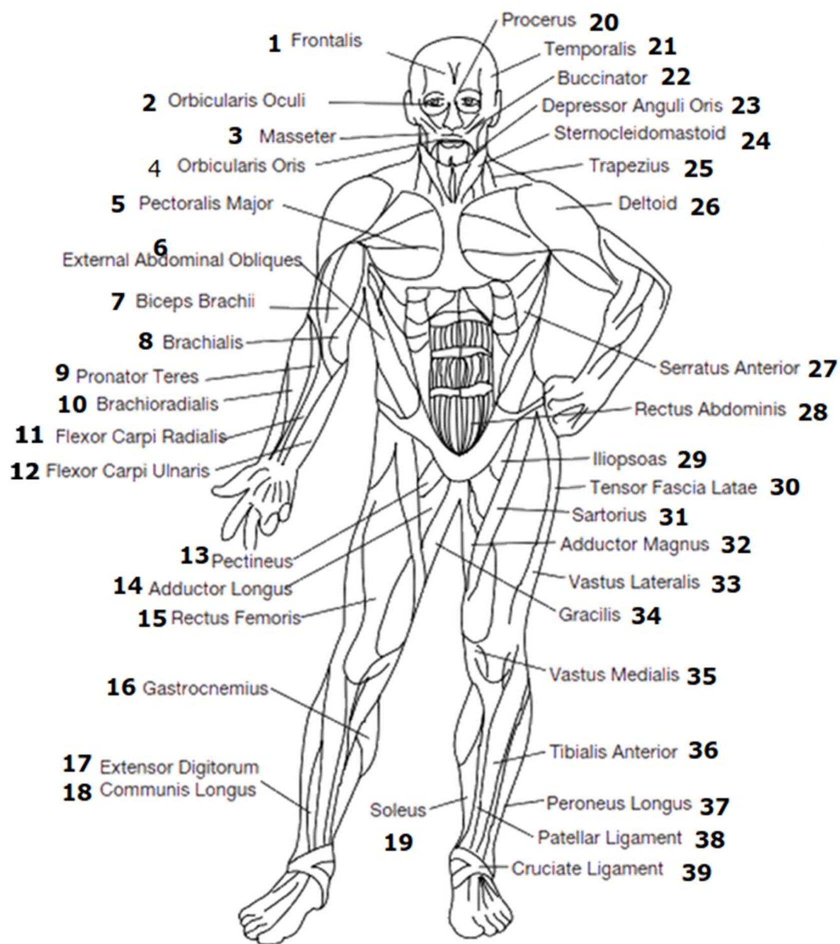

Area: L | R Other Major | Secondary Fixed | Moving

Pain / Type: | | | | Intensity:

Comments:

Area: L | R Other Major | Secondary Fixed | Moving

Pain / Type: | | | | Intensity:

Comments:

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Pain / Type: | | | | Intensity:

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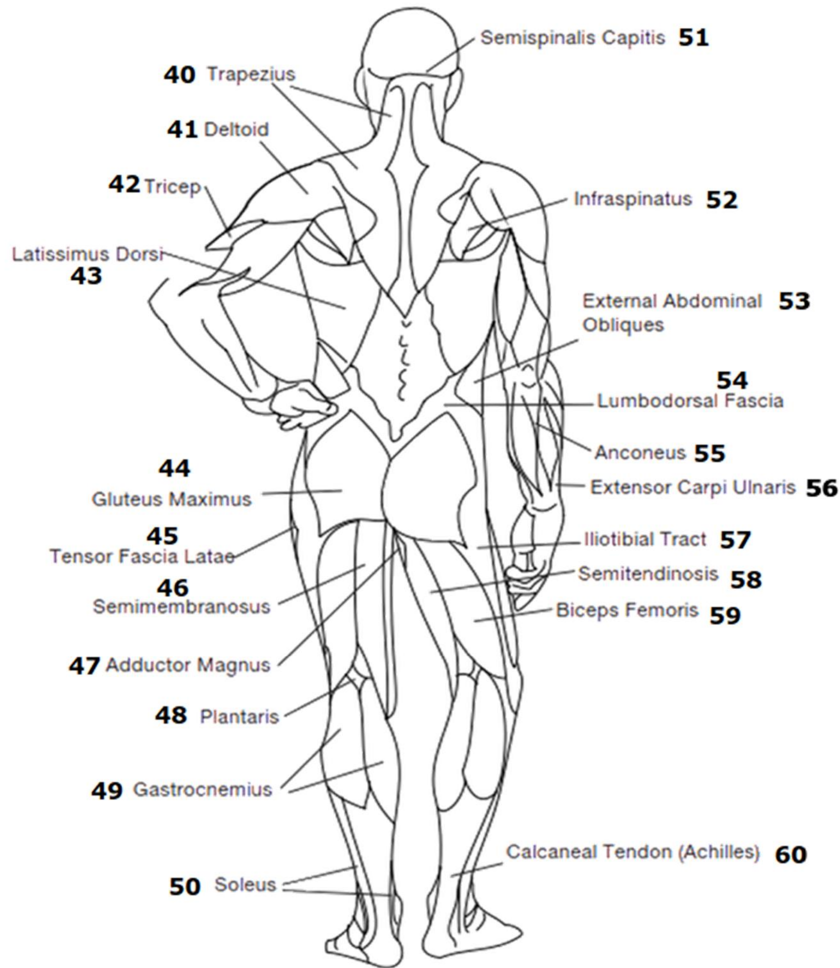

Area: L | R Other Major | Secondary Fixed | Moving

Pain / Type: | | | | Intensity:

Comments:

Area: L | R Other Major | Secondary Fixed | Moving

Pain / Type: | | | | Intensity:

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Comments: