

Client Name _____

Date _____

Therapist Name _____

Duration Of Treatment _____

SUBJECTIVE

Reason for visit:

- Pain relief
- Relieve tension
- Relieve stress (skip rest of section)**
- Relieve anxiety (skip rest of section)**
- Improve quality of life (skip rest of section)**
- Other _____

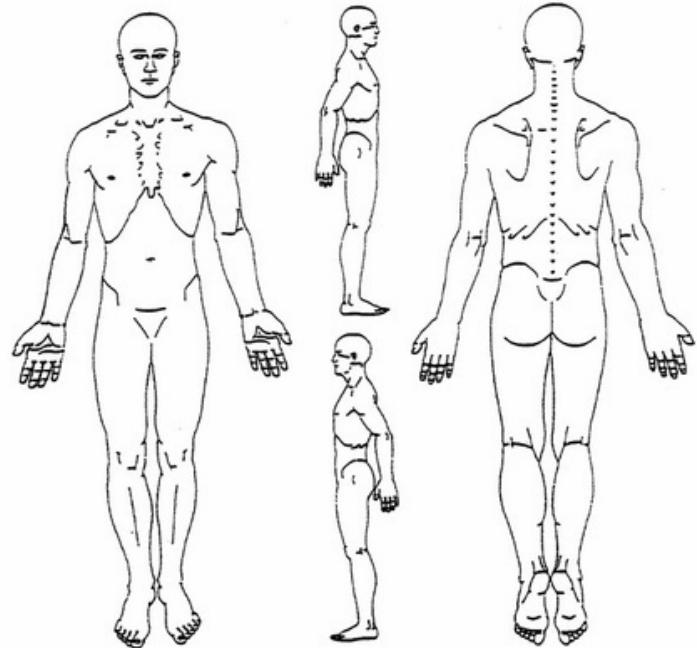
Primary area of pain:

- Adhesion
- Rotation
- Pain
- Tender Point
- Hypertonicity
- ≈ Spasm
- ☀ Inflammation
- ↗ Trigger point
- / Elevation

Intensity of pain: (1-10)

Sensation of pain:

- Dull
- Sharp
- Tender
- Other _____
- Cold
- Burning



Time pattern of pain:

- Constant (pain does not change)
- Intermittent (intensity doesn't change but comes & goes)
- Variable (intensity changes throughout the day)

When did the pain start:

Was there a specific incident that cause this pain?

- Motor vehicle accident
- Fall
- Slept funny
- Work-related
- Sports/exercise
- Other _____

Have you seen other healthcare practitioners about this issue?

- Massage therapist
- Physical therapist
- Chiropractor
- Physician
- Other

Pain/discomfort is brought on or made worse by...

- Work
- Leisure activities
- Sports/exercise
- Sleep
- Other _____

Pain/discomfort feels better with...

OBJECTIVE

POSTURE ASSESSMENT

Spine

- Normal
- Lordosis [**mild moderate severe**]
- Kyphosis [**mild moderate severe**]
- Scoliosis [**mild moderate severe**]

Pelvis

- Normal
- Lordosis [**mild moderate severe**]
- Kyphosis [**mild moderate severe**]
- Scoliosis [**mild moderate severe**]

Shoulders

- Normal
- Lordosis [**mild moderate severe**]
- Kyphosis [**mild moderate severe**]
- Scoliosis [**mild moderate severe**]

Range of Motion

Area _____

- Full range
- Moderate
- Slight restriction
- restriction
- Severe

Intensity (1-10) _____

Notes _____

Palpation

Area _____

- Tension [**mild moderate severe**]
- Texture [**pliable adhesive fibrotic**]
- Tenderness [**mild moderate severe**]
- Temperature [**normal increased decreased**]

TREATMENT

	Modality	Duration
<input type="radio"/> Back	_____	_____
<input type="radio"/> Neck	_____	_____
<input type="radio"/> Shoulders	_____	_____
<input type="radio"/> Face	_____	_____
<input type="radio"/> Hip area	_____	_____

	Modality	Duration
<input type="radio"/> Abdominals	_____	_____
<input type="radio"/> Chest	_____	_____
<input type="radio"/> Face	_____	_____
<input type="radio"/> Breast	_____	_____
<input type="radio"/> Other	_____	_____

ASSESSMENT

How did the client respond to treatment?

PLAN

Treatment plan and self-care recommendations

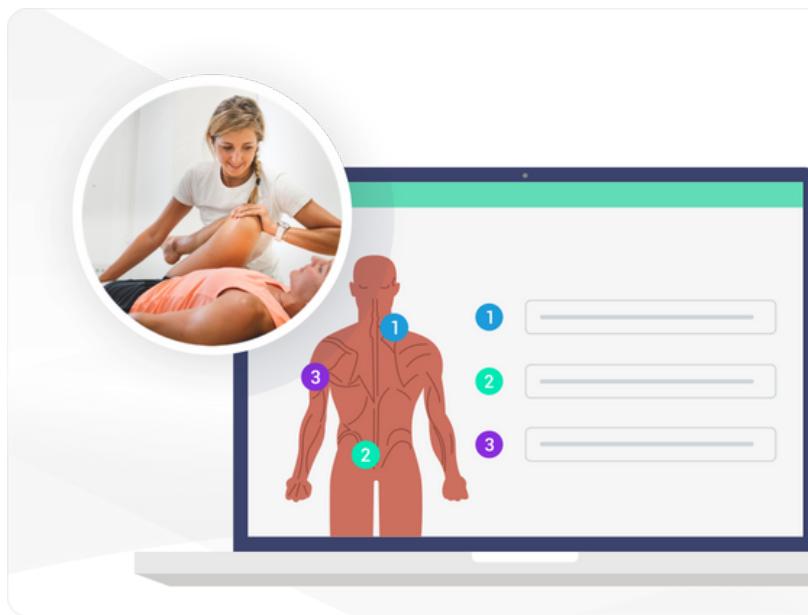
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