

# HEALTH & WELLNESS REPORT

Name: \_\_\_\_\_ Date: \_\_\_\_\_

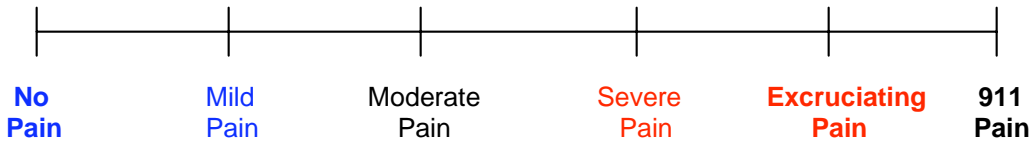
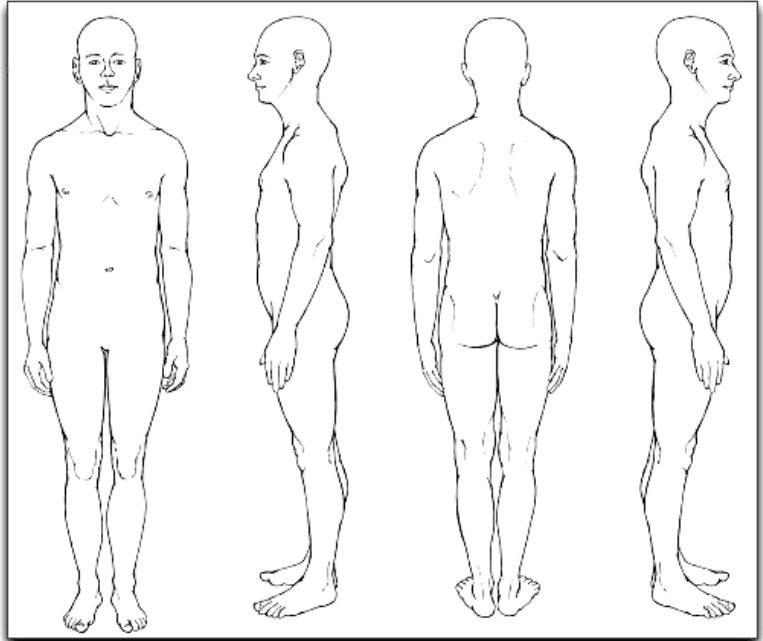
Phone: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

1. Are you currently experiencing any of the following symptoms? If yes, please explain.

Dull Achy Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling or Inflammation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tenderness (w/ touch)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbing or Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Soreness (w/o touch)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Key: P = Pain / Tenderness / Soreness  
S = Stiffness of Joint or Muscles  
I = Inflammation or Swelling  
N = Numbness or Tingling

- Identify **current** symptomatic areas of your body by placing the corresponding **letter(s)** on the figure provided⇒
- **Circle or shade** around each letter to illustrate the area affected by these symptoms
- On the rating scale below, **mark** the point which best represents the overall intensity of your symptom(s)  
↓



2. For this session, what are your goals for attaining health and how can we best assist you?

3. Have there been any changes (improvements or deterioration) in your condition since your last visit? List any new illnesses, injuries, activities or health concerns that are related to current condition:

4. List daily activities affected by symptoms⇒work, exercise, hobbies, etc:

5. List medications or pain relievers taken recently for this condition (Rx or over the counter):

6. I have provided all my known medical information. I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment. I give my consent to receive treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_