|  |  |
| --- | --- |
| **Name:** | **DOB:** |
| **Contact Details:** mobile: email: | |
| **Work Company:** | |
| **Date of Assessment:** | **Referred by:  Contact No.:** |
| **Occupation:** | |
| **Insurance company:** | **Claim No:** |
| **Referring Doctor/Specialist:** | |

**1. DESCRIPTION OF CLIENTS CONDITION AT PRESENTATION**: Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Surgery: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PAIN DETAILS: LOCATION AND LEVEL**

Average Pain: 0 1 2 3 4 5 6 7 8 9 10

Worst Pain: 0 1 2 3 4 5 6 7 8 9 10

* Mechanism of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Aggravating Factors:
* Relieving Factors:
* Frequency of pain:
* Duration of pain:
* Pain Pattern:

**BODY CHART: Report Site of pain/injury/accompanying symptoms**



**2. GENERAL HEALTH / OTHER HEALTH PROBLEMS: (CHD, Diabetes, Asthma, dizziness, Osteoporosis, other joints)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. MEDICATION / Contraindications for Massage?** Medication Type Reason Dose

**4. HISTORY**

* Past/Current treatment:
* Previous (associated) Problems: \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_
* Previous MRI’s/Scans: \_\_\_\_\_\_\_\_\_\_\_\_\_

General Health/Goals: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_