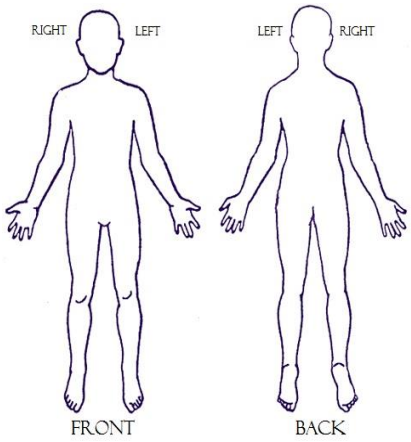
Marilyn Hughey, LMT
2100 NE Broadway, Suite #225
Portland, Oregon 97232
PH: 503-719-5000 FAX: 971-255-1754

Patient Name: _____ **Date of Birth** _____ **Date/Time**_____ / _____

Please circle the area(s) of complaint that describe your pain on the diagrams

1. Aching / dull / sore
2. Burning
3. Numbness or tingling
4. Sharp / shooting
5. Sharp / stabbing
6. Stiffness / tightness
7. Swelling
8. Throbbing
9. Snapping / popping / grinding



For office use only

REFFERAL FROM

_____ REPORT YES NO

S_____

_____

_____

_____

_____

O_____

_____

_____

_____

_____

A_____

_____

_____

_____

P_____

_____

_____

Treatment: Massage 15 30 45 60 MF RELEASE 15 30 THERAPEUTIC EXERCISE 15 30

Recommendations

_____

_____

Progress _____ Frequency/Duration _____ Therapist/Provider Initials _____

Next OV M T W TH F S 1 WK 2 WK 1 MO 6 WK 2 MO