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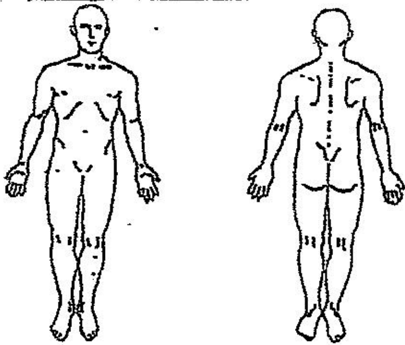
Date ______________ Time ____________

Patient name ____ Date of birth ___________________________

Circle the area(s) of complaint and put the number(s) that describe your pain in the appropriate area(s).

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



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REFERRAL FROM ______________________________ REPORT YES ☐ NO ☐

S ____

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O ____

____

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A ____

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P ____

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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