



Sound Body MYOTHERAPY & MASSAGE

Name _____ Date _____

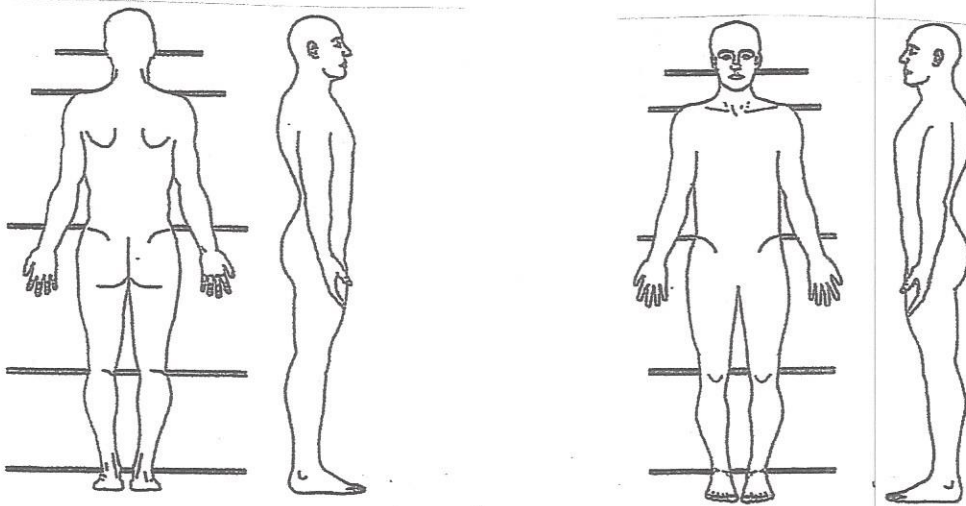
Patient Condition

Fill out all areas that apply:

Reason for Visit: _____

When did your symptoms first appear: _____

Mark on the picture where you have symptoms.



Is your condition the result of a work injury (circle): Yes or No

Is your condition the result of an accident (motor vehicle or other) (circle): Yes or No

Have you been seen by a medical professional for this condition? Yes or No

If yes, who (primary care, urgent care, chiropractor, etc.) and how recently?

Is this condition getting progressively worse? _____



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My symptoms interfere with my (circle all that apply):

Daily Routine

Work

Sleep

Recreation

These things make my symptoms better: _____

These things make my symptoms worse: _____

I am hoping that massage therapy will help me:
