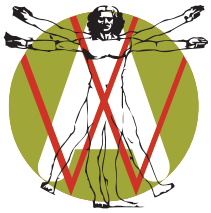


AmyWheeler

Certified Massage Therapist
Certified Neuromuscular Therapist
809 Brandon Ave Suite 312
Norfolk, VA 23507
757-287-5751
amywheeler83@gmail.com

Name: Date:
Address:
City: Zip Code: E-Mail Address:
Cell Phone:
Who referred you?
Birth Date:

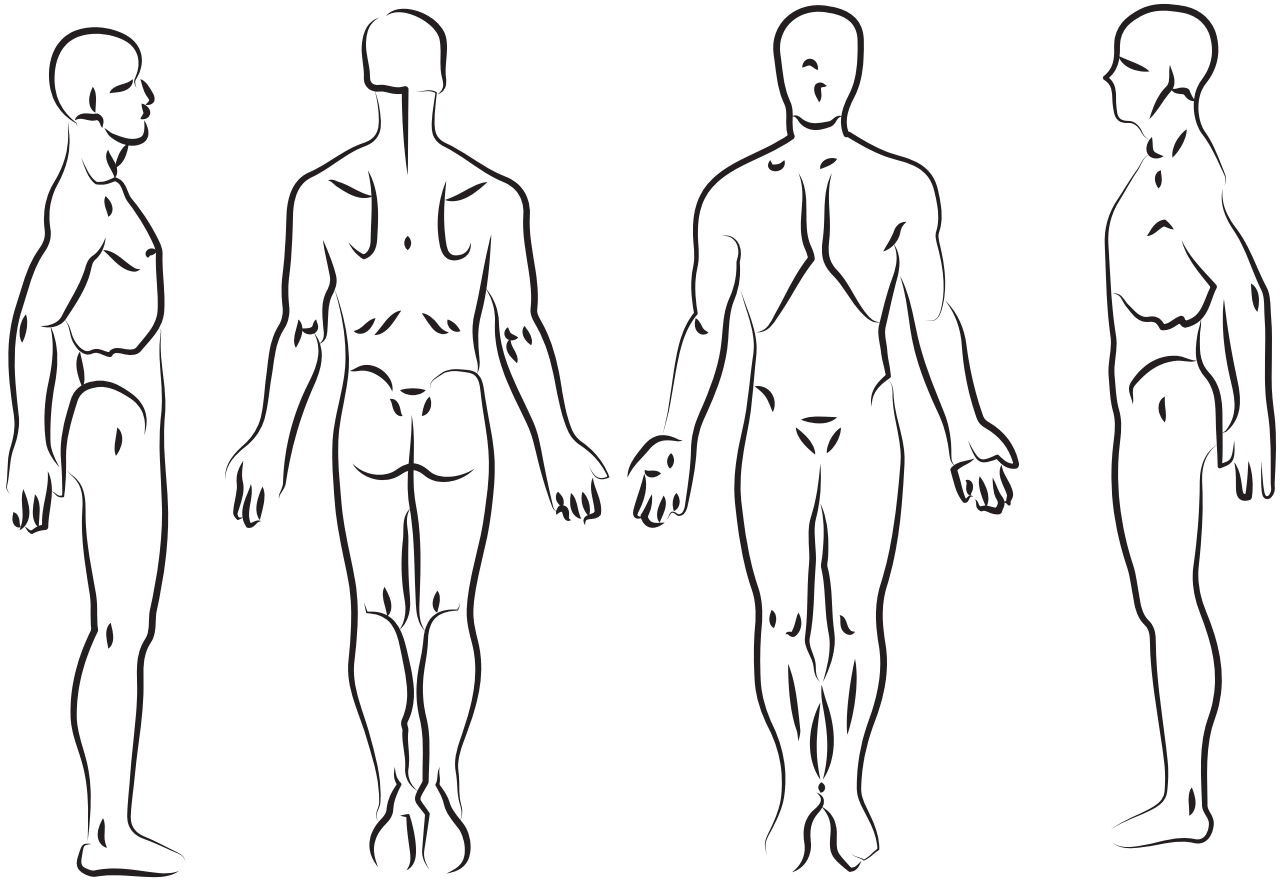
Please check all that apply to you:

☐ Contagious conditions	☐ Skin conditions	☐ Autoimmune disorders
☐ Blood pressure disorders	☐ Cancer/Tumors	☐ Diabetes
☐ Allergies	☐ Cardiovascular conditions	☐ Headaches
☐ Pregnancy	☐ Fibromyalgia	☐ Varicose veins
☐ Blood clots	☐ Reduced sensation	☐ Osteoporosis
☐ Infection (colds, etc.)	☐ Neurological problems	☐ Joint replacement
☐ Arthritis	☐ TMJ syndrome	☐ Injuries(past/recent)

Please list any other conditions you may have:

Please list any medications you are taking:

On the diagram below, mark the places that are bothering you.



Rate your current pain on a scale of 1-10:

How does it feel? (Dull, aching, sore, deep, sharp, shooting, tingling, etc.)

How did it start? (Sudden or gradual onset, traumatic injury, etc.)

How often does it bother you? (Constant, comes and goes, time of day, etc.)

What makes it worse? (Certain movements/activities, stress, etc.)

What makes it better? (Certain movements/activities, heat/ice, etc.)

Do you have a diagnosis? If yes, what is it?

Other therapies/remedies tried and results:

What do you think is the cause of your pain?

Activities of Daily Living

To get a sense of how you are using your body, please respond to the following list, including frequency and intensity.

Job/Work Duties:

Household Duties:

Regular Activities/Hobbies

Exercise:

Sleeping Position:

Other:

What is your current stress level?