AMERICAN MEDICAL MASSAGE NETWORK (AMMN)

Medical Massage Client – Pain Management Form

Client:____________________________________ Date:_______________ Therapist:__________________

Key:

P= Pain or tenderness
S= Joint or Muscle Stiffness
N= Numbness or tingling

Rate the severity of your pain on a scale for 1 (least pain) to 10 (severe pain):

___________________

Type of Pain:

□ Sharp □ Aching □ Cramps

□ Dull □ Shooting □ Stiffness

□ Throbbing □ Burning □ Swelling

□ Numbness □ Tingling □ Other:____________

• When did your symptoms appear?__________________________________________________

• Where were you and/or what were you doing that caused these symptoms?________________

_____________________________________________________________________________

• Is this condition getting progressively worse? □ Yes □ No □ Don’t Know

• How often do you have this pain?____________________________________________________

• Is it constant, or does it come & go?_________________________________________________

• What treatment have you already received for your condition? □ Medications □ Surgery
  □ Physical Therapy □ Massage Therapy □ Chiropractic Services □ None □ ______________________

• Do you smoke? Y/N  Your Height:_______ Your Weight:_______ Blood Pressure:_______ HR____

• What kind of work do you do?________________________________________________________

• Any other information which you think might help us with your treatment plan?____________

_________________________________________________________________________________

Name of your Physician/Healthcare Provider:________________________________________Tel:________________

Signature:________________________________________________________ Date:__________________