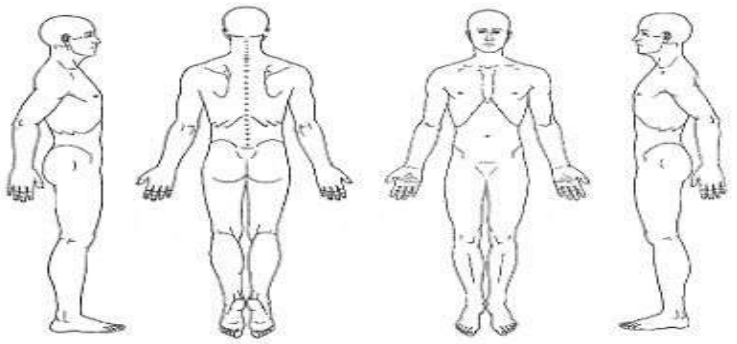
AMERICAN MEDICAL MASSAGE NETWORK (AMMN)

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 (lease 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:_____