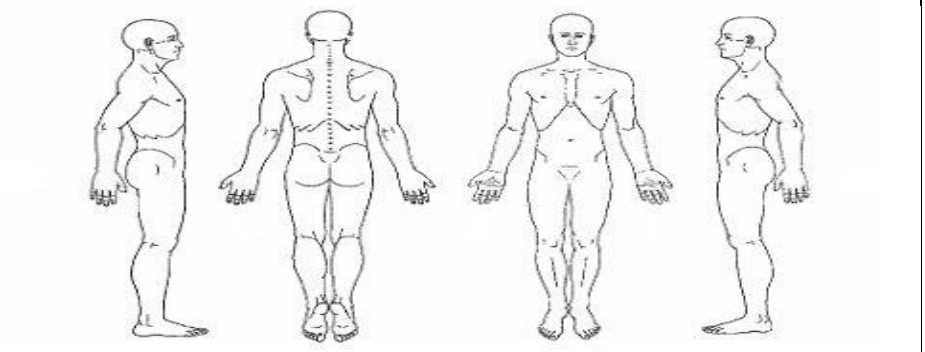
AMERICAN MEDICAL MASSAGE NETWORK (AMMN)

Medical Massage Pain Assessment 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: _____