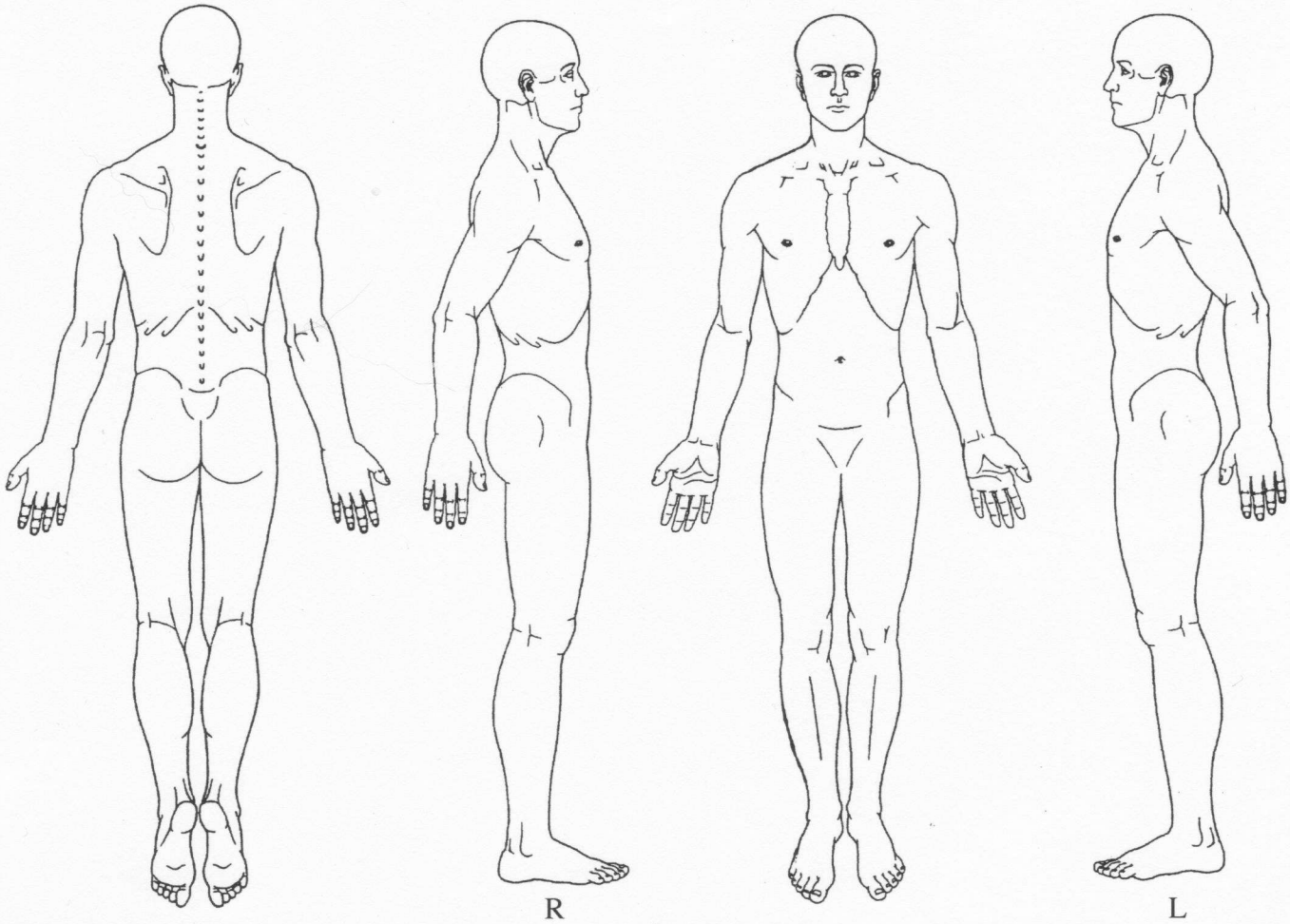
Name _____ Date _____ Time: _____

On the following, please indicate the problem areas and the sensation: Pain, Numbness, Tingling, Stiffness, etc.



Currently, are you experiencing any of the following conditions:

☐ Cold or Flu ☐ Fever ☐ Contagious Disease ☐ Infection ☐ Open Wounds/Sores ☐ Inflammation

Client Comments: _____

O: _____

Signature _____ Date _____ RX _____