

**MASSAGENERD.COM**

**Presents**

**SOAP**  
**Charting**  
**&**  
**Others**

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## Legal Disclaimer

All models are at least 18 years of age. The techniques, ideas, and suggestions in this document are not intended as a substitute for proper medical advice! Consult your physician or health care professional before performing or receiving a massage, particularly if you are pregnant or nursing, or if you are elderly, or if you have any chronic or recurring conditions. Any application of the techniques, ideas, and suggestions in this document is at the reader's sole discretion and risk.

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# Charting

**\*Memory is limited and if it is not written, it did not happen!**

Client \_\_\_\_\_ Date \_\_\_\_\_

○ Trigger Point ● Tender Point △ Pain × Inflamed ☆ Referred Pain  
 ■ Hypertonic + Improved ↓ ROM ↑ ROM



S: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 O: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 A: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 P: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Client: \_\_\_\_\_ Date: \_\_\_\_\_

**S:**  
 What brings you here: \_\_\_\_\_  
 What kind of massage do they want: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Health History: \_\_\_\_\_  
 \_\_\_\_\_

Medications: \_\_\_\_\_  
 Accidents: \_\_\_\_\_  
 Update since last massage: \_\_\_\_\_

\*PAIN  
 \*Characteristics \_\_\_\_\_ \*Symptoms \_\_\_\_\_  
 \*Intensity \_\_\_\_\_ \*Duration \_\_\_\_\_  
 \*Aggravating factors \_\_\_\_\_ \*Alleviating factors \_\_\_\_\_

**O:**  
 Posture: \_\_\_\_\_  
 Muscle tests: \_\_\_\_\_  
 Observation: \_\_\_\_\_  
 Tx goals: \_\_\_\_\_

**A:**  
 Tx given: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Changes: \_\_\_\_\_  
 Posture & Muscle testing (After Tx): \_\_\_\_\_

**P:**  
 Stretching: \_\_\_\_\_  
 Hot or Cold recommendations: \_\_\_\_\_  
 Liked: \_\_\_\_\_  
 Disliked: \_\_\_\_\_  
 What to perform next time: \_\_\_\_\_

When to come back: \_\_\_\_\_ **Ryan Jay Hoyme**

Subjective

Objective

Assessment

Plan

# ACQUIRING INFORMATION

The primary goals of acquiring a client's history are to accurately determine the origin of the person's problem and its impact on the person's life.

Remember to LISTEN to your client, and let those responses guide your interview:

- Make every effort to be as sure as is possible that you understand what your client is trying to tell you.
- Be ready to recognize from your clients' communication any gaps they leave which you the therapist should endeavor to fill by asking appropriate questions.
- Make use of every possible opportunity to use your non-verbal expressions to show your understanding and concern for the client.

The questions that the therapist asks should be, for the most part, open-ended in that they require more than a yes or no response. This allows clients to describe their circumstances in their own words.

## **Questions about the client's problem:**

- What brings you to physical therapy? (if not obvious)
- **Location:** "Where is it located?" Indicate the primary area of pain.

If the person uses:

- **Finger:** indicates a small area, no spreading of discomfort, problem probably not severe, relatively superficial, or both.
- **Whole hand:** diffuse area as primary site : suggests lesion is more severe, more deeply situated, or both
- **Moving hand:** spreading or radiating of the pain : if along a well-defined pathway : dermatome: probably nerve root problem
- **General area, diffuse:** most likely referred pain, possibly visceral in origin

**Onset:** "How and when did it occur?" (Include a description of the mechanism and position of injury.)

How and when did the problem arise (mechanism of injury and date of onset)?

- Gradual versus sudden onset
- Sudden onset.
- Gradual

Position the person was in when the injury was acquired (whether sudden or gradual onset).

Have you started any out-of-the-ordinary activities recently?

- **Characteristics:** "Describe your problem," "How does it feel (pain or other symptoms) and how does it make you feel?" "Does your problem occur at certain times?"
- **Intensity:** "How bad is your problem?" (What impact does this problem have on your life? What are you unable to do because of this problem, with respect to all aspects of your life: self-care, home, work, and leisure?) Have the client rank the problem, using a scale, such as 0 to 10 (give criteria for 0 and for 10, such as 0 = at its best, 10 = at its worst).
- **Duration:** "If certain activities cause you pain, how long does it last after you stop the activity?" "Is it constant, or intermittent?"
- **Aggravating factors:** "What makes the problem worse?" "What do you notice this problem to be associated with?" When do you typically feel the pain?
- **Alleviating factors:** "What makes the problem better?"

### **Assess the Impact of the Problem on the Person's Life:**

Questions about the person should focus on the activities that the person performs and the environments in which they perform them. The activities should address home, work, and leisure/play and should reflect a typical day for the client.

- "Tell me about yourself."
- "Tell me about your home life." (What physical activities do they have to perform at home, describe the home environment, is the person married, do they have children. etc.)
- "Tell me about your work." (What physical activities do they have to perform, describe the work environment, etc.)
- "What do you like to do in your spare time?" (Describe the physical activities and their environments related to hobbies, recreation, etc.)
- "Prioritize the activities from each of these areas that you want to return to doing."
- "Describe your 'typical day' before your problem and after your problem."

### **Additional Questions:**

- "What is it that this problem is keeping you from doing that you want to get back to doing?" This is the client's Outcome Statement. (Have the client prioritize those affected activities, from most to least important).
- "Do you have any other problems?"
- "What medications are you currently taking?"
- "Have you had any previous physical therapy?" (If yes, describe; was it successful?)
- "How do you feel right now?"
- "Is there anything else you would like for me to know?"

During the interview and subsequent treatment, therapists continually seek to gather information from their clients

# CHARTING BASICS

## SOAP Charting Format

A medical charting system, in which:

**S** = Subjective (what the client says, or subjective impressions).

**O** = Objective (what the provider's findings are, or clinical data).

**A** = Assessment (Any changes, the diagnosis, or what the client's condition is).

**P** = Plan for the next treatment, (further studies and suggested treatment).

Note: Not noted in the usual SOAP format, but nonetheless important, is Functional Outcome: What the client can do (or expect to do) because of the treatment rendered. Which charting format is best - Any charting format will do in a jury trial.

## Reasons for charting

Other health care professionals find the format and language familiar and it is a good way to communicate with other health care professionals. Use of charting enhances the image of massage and charting validates massage as curative adjunctive treatment by providing client progress.

Insurance companies accept it as proof of reasonable care and it provides evidence for attorneys as proof of significant injury. It suggests a structure for research using case studies. The main reason is: "Memory is limited and if it is not written, it did not happen."

## Rules for charting

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"><li>▪ Chart in chronological order</li><li>▪ Black ink (Blue is sometimes acceptable)</li><li>▪ Write clearly, concisely and legible</li><li>▪ No ditto marks or initials</li><li>▪ Do not skip lines</li><li>▪ Use correct grammar and spelling.</li><li>▪ Write objectively (no bias, opinions, judgments)</li><li>▪ Draw a line through empty space</li></ul> | <ul style="list-style-type: none"><li>▪ Include the Date, Session #, Time started and Length of session in the left hand corner</li><li>▪ Re-date your entry if moving onto another page</li><li>▪ Write notes ASAP after giving the massage treatment</li><li>▪ Sign the end of the chart with your first name, last name and professional title</li><li>▪ Use phrases - not full sentences.</li><li>▪ Client's name must be on every page.</li></ul> | <ul style="list-style-type: none"><li>▪ Use correct terms and abbreviations.</li><li>▪ Name of client, physician and page # all can go on the top right corner</li><li>▪ The person who observed an occurrence or completed a procedure, records it.</li><li>▪ Use quotes around what the client said</li><li>▪ Never alter therapy records</li><li>▪ Some people say to keep your files for 7 years</li></ul> |
|--|--|--|

## DON'T

- **Don't:** Write biases, value judgments, and opinions.
- **Don't:** Write generalizations (I.e. good, fair, usual, large)
- **Don't:** Erase, use write out, or scribble out an error. Instead draw a single line through entry, write error above it and initial.
- **Don't:** Use erasable or colored ink
- **Don't:** Double chart - info only needs to be in one place
- **Don't:** Squeeze information in - instead write on next available space. Write what and when info occurred. Then document time of entry.

## When to chart

The best time to chart the Subjective part is when the client is getting undressed; the Objective part can be charted when, the client is getting dressed. The Assessment and Plan part can be charted when, the client leaves. It is always best not to leave SOAP notes uncharted over night, because you can and will forget what your treatment entailed.

## Filing

Put your files in alphabetical order with last name first and always put their name on the soap notes. Some people color coat the files for men and women to make it easier. If you have not seen a client for 6-12 months, place them in another file system (But leave them in your office). Never leave the files around for the client to see them.

## Communication

Communication skills are used in listening, speaking, writing, and assessing non-verbal messages. To summarize is briefly stating what the client said and clarify is asking the client more information. When you use exploring, it is going over intake-form

with the client and discovering new facts. When you are not sure what the client said you might need to paraphrase (in other words, what you are saying is...).

### **Open-end and Closed-end questions**

Closed-end questions are questions that you ask the client that require a yes or no answer. Closed-end questions do not get the whole story and you need to ask a lot more questions. Here is an example: Are you hurting today...Do you want a relaxing massage today?

Open-end questions are questions that you ask the client that require more than a yes or no answer. Open-end questions are more valuable and more useful in determining what the client wants. Here is an example: Where do you feel the pain right now...Where does the pain start?

### **Abbreviations**

The use of abbreviations can be useful to expedite charting, but be sure that everyone reading the chart knows what the abbreviations mean. The problem with abbreviations is that they are not regulated and people make their own abbreviations up. Be careful what you choose to abbreviate and make sure the average healthcare worker can understand them.

### **Late entries**

Must clearly be identified as late entries and note the time of the event and the time of the late entry as well as the appropriate identification. Documenting activities out of chronological order may suggest that the record is not accurate. This suggestion may be tempered by appropriately recorded late entries. Never leave blank lines for someone else to insert notes. If there are blanks in your record you must put a single line through the area to ensure yourself and anyone reading the record that there was no opportunity to alter the original record. Inserted text or text that extends beyond the recognized writing or recording area may also suggest that the notations were made as an afterthought or to cover-up activities.

### **Corrections**

In a health record must be made in an honest and straightforward manner. Notes that have been erased or obliterated suggest that there is something to hide.

When you are correcting an entry make sure that the mistake is still legible (e.g., draw a single straight line through the entry). Initial the error and note that it is an error or draw attention to the correction. Do not use "white-out."

### **Maintaining Client Confidentiality**

- Never write client's full name on paper that will leave your place of business.
- Keep paperwork in secure areas.
- Never leave computer if you are logged in.
- Never give anyone your computer access code.
- Chart in private area. "Who may be able to see what you are reading/writing?"

# SOAP CHARTING

## SUBJECTIVE

To make it simple it means, "What is the client telling you?" The subjective part can also include anything the client writes on the health form and any verbal and nonverbal communication they give you (Studies indicate that as much as 94 percent of communication is nonverbal). Here are more things that can go in the subjective part: Medications they are on, diseases they have, previous accidents, special precautions to take, current problems, what type of massage they want, what areas they want massaged and what areas do they not want massaged.

A good way to find out how they handle their day-to-day activities is with a pain questionnaire (The form is one that rates all activities and how much pain they have with each).

### **Pain questions to ask:**

- Where is the location of the pain?
- How bad is the pain at any given time?
- How long have you had the pain?
- Have you ever had this pain in the past?
- What is the frequency of the pain?
- How does the pain start?
- Is the pain more on one side than the other?
- Does your job increase your pain?
- What aggravates the pain?
- Does anything relieve the pain?
- If you do not know how you got the pain, have you ever injured yourself there before?
- "Tell me about yourself."
- "Tell me about your home life." (What physical activities do they have to perform at home, describe the home environment, etc.)
- "Tell me about your work." (What physical activities do they have to perform, describe the work environment, etc.)
- "What do you like to do in your spare time?" (Describe the physical activities and their environments related to hobbies, recreation, etc.)
- "Prioritize the activities from each of these areas that you want to return to doing."
- "Describe your 'typical day' before your problem and after your problem."
- "What is it that this problem is keeping you from doing that you want to get back to doing?" This is the client's Outcome Statement. (Have the client

prioritize those affected activities, from most to least important).

- "Do you have any other problems?"
- "What medications are you currently taking?"
- "Have you had any previous physical therapy?" (If yes, describe; was it successful?)
- "How do you feel right now?"
- "Is there anything else you would like for me to know?"
- **Characteristics:** "Describe your problem," "How does it feel (pain or other symptoms) and how does it make you feel?" "Does your problem occur at certain times?"
- **Intensity:** "How bad is your problem?" (What impact does this problem have on your life? What are you unable to do because of this problem, with respect to all aspects of your life: self-care, home, work, and leisure?) Have the client rank the problem, using a scale, such as 0 to 10 (give criteria for 0 and for 10, such as 0 = at its best, 10 = at its worst).
- **Duration:** "If certain activities cause you pain, how long does it last after you stop the activity?" "Is it constant, or intermittent?"
- **Aggravating factors:** "What makes the problem worse?" "What do you notice this problem to be associated with?" When do you typically feel the pain?
- **Alleviating factors:** "What makes the problem better?"

**Subjective simplified** - Any info the client tells you (I had my right femur broke in 97), Health history, client goals (what the client wants out of the massage), update (what happened since last massage), symptom's (headaches), location (upper back), intensity (scale of 1-10), duration (couple hours after sitting for a long time), frequency (3 times a week), onset (when sitting for long periods of time), aggravates (lifting heavy things), relieves (aspirin, ice), pain questionnaire.



## OBJECTIVE

To make it simple it means, "The data the therapist takes from palpation." It also means: visual-postural analysis, limps, muscle guarding, holding patterns, inconsistencies in movements, atrophy, hypertrophy, bruises, abrasions, scars, swelling, redness, skin irregularities, varicose veins, breathing patterns and prosthetics.

Treatment goals can be added to define the intention of your massage choices and that they insure that your treatment-plan has a purpose.

**Objective simplified** - Visual observations (scars, postural analysis), palpable findings (hypertonic, spasm), test results (change in ROM findings), treatment goals (why you are doing the treatment you are doing), the massage and techniques you did (sports massage, trigger point therapy, worked right rhomboid and hypertonic).

## ASSESSMENT

To make it simple it means, "The therapist evaluates what she or he is doing." It also means: Changes in client's condition because of treatment and changes in symptoms. (Sometimes people include the application in the assessment part)

**Assessment simplified** - Changes in the client's condition (more flexibility in neck), and symptoms after or during the massage (headache slightly improved).

**S.O.A.A.P. (Application)** - Sometimes therapists will include the treatment given in the assessment or make "S.O.A.A.P." notes.

## PLAN

To make it simple it means, "The client's next session will consist of, and any homework given to the client." A treatment plan for next session can be included: what worked, what did not, what you did not address, and what you want to make sure to work on next time. If no changes have been noted in the assessment part, you may have ideas for next time. Recommend the client to get a massage on a regular basis: 1x / wk /4wks = eval (one time a week for four weeks and then evaluate them at the end of the four weeks). Always recommend how many times for them to come back, they might not follow it but at least you tried and you are looking out for their best interest.

Homework is just that, things the client can perform at home to help with the process of their treatment (stretching, exercise, ice/heat packs, change in diet) try alternatives to pain medication (ice /heat packs). Do not contradict what the primary health care provider instructed. Help them make short and long-term goals, short-term is weekly or monthly (I would like you to sit more than an hour without hurting in the next month) and long-term is 3, 6, 9 or 12 month periods.

**Plan simplified** - What worked and did not work (trigger point work was too much on right rhomboids, continue to concentrate on right low back), what to work on next time (low back, left leg...), how often to come in for treatment (2x / wk / 4wks = evaluation), what things they can do on their own (stretching, ice, heat...).

**S.O.A.P.P. (Procedure)** - Sometimes therapists will include "S.O.A.P.P." and the Procedure part will include the treatment you gave and the last "P" will be the Plan.

**Next visit** - Review your notes on the client, before he or she arrives for their appointment. The subjective part is just an update since the last time you gave them a massage.

## HOPS CHARTING

This is another form of charting.

- **History** (What the client tells you and what he or she writes down)
- **Observation** (Any visual things you see)
- **Palpation** (Anything you feel)
- **Special tests** (Muscle testing, R.O.M. or other tests)

## CARE CHARTING

This is another form of charting.

- **Condition of the client** (Current condition of the client)
- **Action taken** (Type of massage given and length of treatment)
- **Response of client** (Physiological changes noted during and after the session)
- **Evaluation** (Overall evaluation of the session)

# FOCUS CHARTING

This is another form of charting.

**Goal:** to make the client's concerns and strengths the focus of care. This is the first holistic charting.

Format of charting is "DAR."

**D - Data**

- Subjective and Objective

**A - Action**

- Actual and future massage actions. This includes changes in plan of care.

**R - Response**

- Client response to massage treatment.

**Osteopaths often use a system of examination called ARTT to look for signs of somatic dysfunction:**

- **A** = Asymmetry where there is an obvious difference in the appearance in an area compared to the opposite side.
- **R** = Range of motion where an area is either moving normally, in a restricted way, or is showing signs of hypermobility.
- **T** = Tissue texture where there is a difference between two areas when touching the soft tissues (skin, fascia, muscles).
- **T** = Tissue tenderness where there is a difference in the painful pressure threshold to touch in the muscles in an area.

# DISCLAIMERS

I understand that the massage/bodywork/release work I will receive is provided for the basic purpose of relief from stress and muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that pressure or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork/release should not be considered a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified health care specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of a session should be considered as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and have answered all questions honestly. I agree to keep the practitioner informed of any changes to the above profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment for the full time scheduled. I agree to honor the 24-hour cancellation policy or else be responsible for payment of 50% of the appointment fee that would have been due.

The following sometimes occur during massage. They are normal responses to relaxation and/or touch, and need not be embarrassed nor suppress them. Movement or release of intestinal gas - crying - laughing - strong emotions - sighing - groaning - yawning - softening of muscle tissue - cognitive or felt memories - stomach gurgling - need to move or change position. At any time during your session please let me know if there is anything I can do to help you feel more comfortable. I understand that the services provided are not a replacement for medical or psychological care and that any information provided is not prescriptive or diagnostic in nature and is for educational purposes only. I also give my permission for the CMT(s) with whom I work to discuss information pertinent to my condition(s) and treatment, with my other health care providers.

I have provided all my known medical information. The general benefits of massage, possible massage contraindications, and the treatment procedure have been explained to me. I acknowledge that massage is not a substitute for medical diagnosis and treatment. I give my consent to receive treatment.

The general benefits of massage, possible massage contraindications, and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

Please carefully read the information, and then sign. A referral from your primary care provider may be required prior to service being provided. I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because massage/bodywork perform under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioners part should I forget to do so. It is also understood that any elicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I declare that the information I have given is correct and promise to notify the Therapist should there be any changes to my health. As far as I am aware I can undertake treatment without any adverse affects. I have been fully informed about any contraindications and am willing to proceed with the treatment.

# ABBREVIATIONS

<b>a **</b> Before	<b>CTS</b> Carpal tunnel syndrome	<b>ext</b> Extension	<b>L-S</b> lumbosacral	<b>MCP</b> Metacarpophalangeal	<b>q2h</b> Every 2 hours	<b>s/p</b> Status post
<b>add</b> Adduction	<b>CA</b> Cancer	<b>ext rot</b> External rotation	<b>L-spine</b> Lumbar spine	<b>MVA</b> Motor vehicle accident	<b>RLE</b> Right lower extremity	<b>S.T.</b> Speech therapy
<b>A</b> Active	<b>cc</b> Chief complaint	<b>FWB</b> Full weight bearing	<b>LOB</b> Loss of balance	<b>NWB</b> Non-weight bearing	<b>R *</b> Right	<b>T/C</b> Telephone call
<b>A*</b> Assistance	<b>CHF</b> Congestive heart failure	<b>FROM</b> Full range of motion	<b>LTG</b> Long term goal	<b>Neg.</b> Negative	<b>RLQ</b> Right lower quadrant	<b>tol.</b> tolerate(s)(ed)
<b>AA</b> Active assisted	<b>c/o</b> Complains of	<b>fib</b> Fibula	<b>LUE</b> Left upper extremity	<b>npo</b> Nothing by mouth	<b>rad.</b> Radius	<b>TENS</b> Trans Q elect. nerve stim.
<b>ax</b> Axillary	<b>COG</b> Center of gravity	<b>f/u</b> Follow up	<b>LTM</b> Long term memory	<b>NKDA</b> No known drug allergies	<b>RA</b> Rheumatoid arthritis	<b>TMJ</b> Temporomandibular joint
<b>abd</b> Abduction	<b>CG</b> Contact guard	<b>flex</b> Flexion	<b>LOM</b> Loss of memory	<b>OT</b> Occupational therapy	<b>RUQ</b> Right upper quadrant	<b>THR</b> Total hip replacement
<b>ACL</b> Anterior cruciate ligament	<b>co-ord</b> Coordination	<b>FH</b> Family history	<b>L*</b> Left	<b>OS</b> Left eye	<b>reps.</b> Repetitions	<b>TIA</b> Transient ischemic attack
<b>ADL</b> Activities of daily living	<b>cont.</b> Continue	<b>f/b</b> Followed by	<b>LAC</b> Long arm cast	<b>OU</b> Each eye	<b>po</b> By mouth	<b>Therex</b> Therapeutic exercise
<b>AFO</b> Ankle foot orthosis	<b>CP</b> Cold pack/cerebral palsy	<b>F</b> Fahrenheit	<b>LAQ</b> Long arc quad set	<b>p **</b> After	<b>rot.</b> Rotation	<b>tid</b> Three times a day
<b>AKA</b> Above knee amputation	<b>c-spine</b> Cervical spine	<b>fx.</b> Fracture	<b>LB</b> Low back	<b>prn</b> As needed	<b>RN</b> Registered nurse	<b>temp</b> Temperature
<b>amb.</b> Ambulate	<b>c **</b> With	<b>gastroc</b> Gastrocnemius	<b>LBP</b> Low back pain	<b>PROM</b> Passive range of motion	<b>RUE</b> Right upper extremity	<b>TPR</b> Temperature, pulse, respirations
<b>ant.</b> Anterior	<b>D *</b> Dependent	<b>HS</b> At bedtime	<b>LUE</b> Left upper extremity	<b>post.</b> Posterior	<b>ROM</b> Range of motion	<b>Tx.</b> Treatment
<b>AROM</b> Active range of motion	<b>DIP</b> Distal interphalangeal	<b>HNP</b> Herniated nucleus pulposus	<b>med.</b> Medial	<b>Pos.</b> Positive	<b>Rx</b> Prescription	<b>trax</b> Traction
<b>AAROM</b> Active-assisted ROM	<b>DAFO</b> Dynamic ankle/foot orthosis	<b>HP</b> Hot pack	<b>med rot</b> Medial rotation	<b>PDR</b> Physician's desk reference	<b>STG</b> Short term goals	<b>US</b> Ultrasound
<b>ASAP</b> As soon as possible	<b>D/C</b> Discontinued	<b>hosp.</b> Hospital	<b>MH</b> moist heat	<b>PCL</b> Posterior cruciate ligament	<b>sx</b> Symptoms	<b>URI</b> Upper respiratory infection
<b>art</b> Articulation	<b>dep</b> Dependent	<b>HEP</b> Home exercise program	<b>MI</b> Myocardial infarction	<b>PIP</b> Proximal interphalangeal	<b>sup.</b> Supine	<b>UTI</b> Urinary tract infection
<b>ASA</b> Aspirin	<b>DIP</b> Distal interphalangeal	<b>H/O</b> History of	<b>max.</b> Maximum	<b>pt.</b> Client	<b>STM</b> Short term memory	<b>vo</b> Verbal orders
<b>BLE</b> Bilateral lower extremities	<b>DM</b> Diabetes mellitus	<b>EKG</b> Electrocardiogram	<b>min.</b> Minimum	<b>PMH</b> Past medical history	<b>SLR</b> Straight leg raise	<b>ve's</b> Verbal cues
<b>bid</b> Two times a day	<b>DOB</b> Date of birth	<b>Hx</b> History	<b>mob.</b> Mobilization	<b>PWB</b> Partial weight bearing	<b>SOB</b> Short of breath	<b>vss</b> Vital signs stable
<b>BKA</b> Below knee amputation	<b>DNR</b> Do not resuscitate	<b>Hr</b> Hour	<b>mod.</b> Moderate	<b>pt.</b> Client	<b>S*</b> Supervision	<b>VS</b> Vital signs
<b>Bkwd</b> Backwards	<b>disl.</b> Dislocate	<b>I *</b> Independent	<b>LLQ</b> Left lower quadrant	<b>PMH</b> Past medical history	<b>sm</b> Small	<b>WFL</b> Within functional limits
<b>BUE</b> Bilateral upper extremities	<b>DJD</b> Degenerative joint disease	<b>IV</b> Intravenous	<b>MTP</b> Metatarsophalangeal	<b>PWB</b> Partial weight bearing	<b>s **</b> Without	<b>WNL</b> Within normal limits
<b>B*</b> Bilateral	<b>DX, Dx, dx</b> Diagnosis	<b>IR</b> Int. rot./infrared	<b>MMT</b> Manual muscle test	<b>pros.</b> Prosthesis	<b>SAC</b> Short arm cast	<b>w/c</b> Wheelchair
<b>BP</b> Blood pressure	<b>e.g.</b> For example	<b>jt.</b> Joint	<b>MR</b> Mental retardation	<b>PSIS</b> Posterior superior iliac spine	<b>S-C</b> sternoclavicular	<b>WB</b> Weight bearing
<b>BOS</b> Base of support	<b>ES</b> Electrical stimulation	<b>KAFO</b> Knee ankle foot orthosis	<b>MRI</b> Magnetic resonance image	<b>P.T.</b> Physical therapy	<b>SBA</b> Standby assistance	<b>WBAT</b> Weight bear as tolerated
<b>BR</b> bed rest	<b>ECF</b> Extended care facility	<b>lat.</b> Lateral	<b>MT</b> Massage Therapist	<b>q</b> Every	<b>shld.</b> Shoulder	<b>X</b> Times
<b>BRP</b> Bathroom privileges	<b>EMG</b> Electromyogram	<b>lat.</b> Lateral	<b>MC</b> Metacarpal	<b>qid</b> 4 times a day	<b>SCM</b> Sternocleidomastoid	<b>#</b> Pounds
<b>CNS</b> Central nervous system	<b>ER</b> Emergency room	<b>LUQ</b> Left upper quadrant	<b>MS</b> Multiple sclerosis	<b>qd</b> Every day	<b>SCI</b> spinal cord injury	
		<b>LCL</b> Lateral collateral ligament	<b>MAFO</b> Molded ankle foot orthosis	<b>qh</b> Every hour	<b>S&amp;S</b> Signs and symptoms	
		<b>LLE</b> Left lower extremity	<b>MCL</b> Medial collateral ligament	<b>q4h</b> Every 4 hours	<b>SI</b> Sacroiliac/steroid injection	
		<b>L-Trax</b> Lumbar traction			<b>SLP</b> Speech/lang. pathologist	

\* Signifies a circle should be placed around the letter.

\*\* Signifies that a line should be drawn over the letter.

# INFORMED CONSENT

I, \_\_\_\_\_, understand that the massage therapy given to me by a massage therapist is for the purposes of stress reduction, pain reduction, relief from muscle tension, increasing circulation, or specific reasons noted here: \_\_\_\_\_

\*I understand that massage therapy does not diagnose illness or disease, or any other disorder, and that the massage therapist does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.

\*I understand that massage therapy is not a substitute for medical examinations or medical care, and that it is recommended that I am concurrently working with my primary caregiver for any condition I may have.

\*I understand that I have the right to have any part of my body not massaged (Please let the therapist know).I have stated all my known physical conditions, medical conditions, and medications, and I will keep the massage therapist updated on any changes.

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# FEEDBACK FORM

Name of Student Massage Therapist: \_\_\_\_\_

Disposition of the client (you) before the massage: \_\_\_\_\_

Disposition of the client (you) after the massage: \_\_\_\_\_

## PLEASE ANSWER MORE THAN YES OR NO

(The Massage student will not get this back for one week)

1. Did the therapist introduce himself/herself and call you by your name?
2. Did the therapist explain what they were going to do before you started your treatment (Where to put your clothes, How to start the treatment face up or face down on the table, To take your jewelry off, And anything else)?
3. Did the therapist ask you if you wanted a bolster under your knees when you were face up and under your ankles when you were face down?
4. Were you comfortable during the treatment?
5. Did the therapist go over the health form with you (Did she or he ask you any questions)?
6. What areas did you not want massaged (Face, Scalp, Arms, Hands, Stomach, Legs, Feet, Back and Side of Glutes)?
7. What areas did the therapist not massage (Face, Scalp, Arms, Hands, Stomach, Legs, Feet, Back and Side of Glutes)?
8. Did the therapist have any odor (Yes\_\_\_\_, No\_\_\_\_)?
9. Did the therapist keep his or her hands on you: Most of the time\_\_\_\_, Some of the time\_\_\_\_?
10. Did there seem to have a flow with the massage: Most of the time\_\_\_\_, Some of the time\_\_\_\_, Not much at all\_\_\_\_?
11. Therapist's personality (1-10, 10 being the best).
12. In general, evaluate the effectiveness of the massage (1-10, 10 being the best).
13. Would you ever make an appointment with this therapist out in public (Yes\_\_\_\_, No\_\_\_\_)?
14. Therapist's strong points...
15. Therapist's weak points (Please write at least one thing they could improve on)...
16. Did the therapist explain the possible side-effects from receiving a massage (Soreness, Dizziness, Flu-like symptoms, Dehydration, Bruising, and Bringing up old pain)?
17. If you ever received a professional massage before; what did you like or dislike compared to your other massages?
18. Any Other Comments?

# HEALTH FORM

Your answers to the following questions will be kept confidential.  
They will be seen only by myself and are requested so that I may provide you with better care.

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (day) \_\_\_\_\_ Phone (eve) \_\_\_\_\_ Phone (cell) \_\_\_\_\_  
Age \_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_ Pregnant? \_\_\_ E-Mail \_\_\_\_\_  
Address \_\_\_\_\_  
Occupation \_\_\_\_\_ What do you do for exercise? \_\_\_\_\_

Have you received previous a professional massage? \_\_\_ Who referred you? \_\_\_\_\_

Reason(s) for coming for massage now: \_\_\_\_\_

Are there any areas of your body that you would like me to focus more time on during the massage:  
(Face) (Scalp) (Neck) (Shoulders) (Stomach) (Upper back) (Mid back) (Lower back) (Arms) (Hands) (Gluteals) (Legs) (Feet)

Are there any areas that I should avoid when giving you a massage, either for medical reasons, or because you bruise easily, or for personal reasons? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What pressure would you prefer? (Soft / Light touch) (Med / Firm touch) (Hard / Deep touch)

Please include ALL muscle, bone, or joint injuries even if not recent: \_\_\_\_\_  
\_\_\_\_\_

Allergies? \_\_\_\_\_ Drugs: Prescription/Recreational? \_\_\_\_\_

Is there anything else I should know? \_\_\_\_\_  
\_\_\_\_\_

\*The following may occur during massage. They are normal responses to relaxation and/or touch, and need not be embarrassed nor suppress them. Movement or release of intestinal gas - crying - laughing - strong emotions - sighing - groaning - yawning - softening of muscle tissue - cognitive or felt memories - stomach gurgling - need to move or change position. At any time during your session please let me know if there is anything I can do to help you feel more comfortable.  
\*There are side effects with massage: Bruising, Flu-like symptoms, Muscle soreness and many others.  
\*I understand that massage therapy does not diagnose illness or disease, or any other disorder, and that the massage therapist does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.  
\*I understand that massage therapy is not a substitute for medical examinations or medical care, and that it is recommended that I am concurrently working with my primary caregiver for any condition I may have.  
\*I have stated all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.  
\*I also give my permission for the CMT(s) with whom I work to discuss information pertinent to my condition(s) and treatment, with my other health care providers.

Client's Signature \_\_\_\_\_ Date \_\_\_ / \_\_\_ / 20\_\_\_



# HEALTH QUESTIONNAIRE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 How did you hear about this place: \_\_\_\_\_ E-mail address: \_\_\_\_\_

\*If you have a specific medical condition or symptom, receiving or performing massage may be contraindicated or require modification. A referral from your primary care provider may be requested prior to receiving &/or performing massage.  
 DISCLAIMER: This place of business will not be held liable for any injury or condition that arises from application of massage despite completion of this form. The form is intended as an assessment tool that is routinely used in the massage profession and serves as a guide for application of massage. Your e-mail address will not be sold or given to anyone else.

\*Have you received a professional massage before? \_\_\_\_\_  
 \*Are you on any medications (List them)? \_\_\_\_\_

**\*Are there any areas of your body that you  
 ‘DO NOT’ want massaged:**

(Face) (Scalp) (Neck) (Upper Chest) (Shoulders) (Stomach) (Upper back) (Mid back)  
 (Lower back) (Arms) (Hands) (Side of glutes) (Legs) (Feet)

**\*Please circle the condition/s that you have now or had experienced in the past & add comments to clarify.**

**Integumentary System (Skin)**

- Boils
- Fungal infections
- Herpes Simplex
- Warts/moles
- Eczema
- Psoriasis
- Skin Cancer
- Skin allergies
- Rashes
- Burns including Sunburn
- Scars
- Cosmetic surgery
- Bruise easily
- Other: \_\_\_\_\_
- Comments: \_\_\_\_\_

**Circulatory/Lymph/  
 Endocrine System**

- Anemia
- Phlebitis
- Heart disease/condition
- High Blood Pressure
- Low Blood Pressure
- Varicose Veins
- Diabetes
- Clotting disorders
- Edema
- Hodgkin’s disease
- AIDS, HIV
- Chronic Fatigue Syndrome
- Lupus
- Cold/flu/fever (Currently)
- Hypo/Hyperthyroidism
- Leukemia/lymphoma
- Other: \_\_\_\_\_
- Comments: \_\_\_\_\_

**Respiratory System (Breathing)**

- Sinus problems
- Tuberculosis
- Asthma/Emphysema
- Other: \_\_\_\_\_
- Comments: \_\_\_\_\_

**Musculo-skeletal System (Muscle)**

- Fibromyalgia
- Rheumatoid Arthritis
- Osteoarthritis
- TMJ dysfunction
- Strains, sprains, tendonitis
- Bursitis
- Carpal tunnel syndrome
- Thoracic outlet syndrome
- Cramping, spasms, soreness
- Broken or fractured bones
- Persistent pain
- Loss of motion or mobility
- Difficulty with prolonged stance
- Unable to comfortably lie on both sides
- Other: \_\_\_\_\_
- Comments: \_\_\_\_\_

**Digestive/Urinary System**

- Cirrhosis
- Ulcer
- Gallstones
- Hepatitis
- Irritable Bowel Syndrome
- Kidney stones
- Reflux esophagitis
- Bladder infection
- Eating disorder
- Other: \_\_\_\_\_
- Comments: \_\_\_\_\_

**Nervous System**

- Multiple Sclerosis
- Spinal cord injury
- Brain injury
- Numbness/tingling
- Headaches
- Stroke
- Seizure disorder
- Reduced sensation
- Other: \_\_\_\_\_
- Comments: \_\_\_\_\_

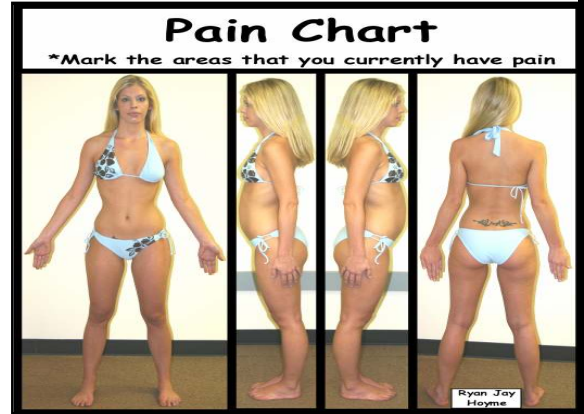
**Reproductive System**

- Breast Cancer
- Ovarian cysts
- Painful Menstruation
- Pregnant
- Prostate Cancer
- Pelvic Inflammatory Disease
- Other: \_\_\_\_\_
- Comments: \_\_\_\_\_

**Other**

- Hearing impaired
- Visually impaired
- Insomnia
- Cancer (Other than specified above)
- Alcoholism/substance abuse
- Heavy caffeine or nicotine user
- Physical abuse
- Psychological condition
- Taking prescribed medication
- Using over the counter medication
- Accidents: \_\_\_\_\_
- Surgery other than specified above: \_\_\_\_\_

Other conditions: \_\_\_\_\_  
 Comments: \_\_\_\_\_



I have stated all conditions that I am aware of and that this information is true and accurate to the best of my knowledge. I agree to inform my massage therapist immediately of any change in conditions as stated above. I acknowledge that this information is confidential and intended for review by fellow massage therapists; that a medical referral may be requested of me; and that "This place of business" is not held liable for the management or arising of conditions.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# LARGE PRINT HEALTH FORM

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

How did you hear about this place:

\_\_\_\_\_  
\*Have you received a professional  
massage before? \_\_\_\_\_

**\*Are there any areas of your body  
that you 'do not' want massaged:**

(Face) (Scalp) (Neck) (Upper Chest) (Shoulders)  
(Stomach) (Upper back) (Mid back) (Lower back)  
(Arms) (Hands) (Gluteals) (Legs) (Feet)

\*Please list any surgeries you have had in  
the past \_\_\_\_\_

\*Please list any accidents you have had in the  
past \_\_\_\_\_

\*Please list any allergies you have \_\_\_\_\_

\*Please list any diseases you have \_\_\_\_\_

\*List any medications you are currently on? \_\_\_\_\_

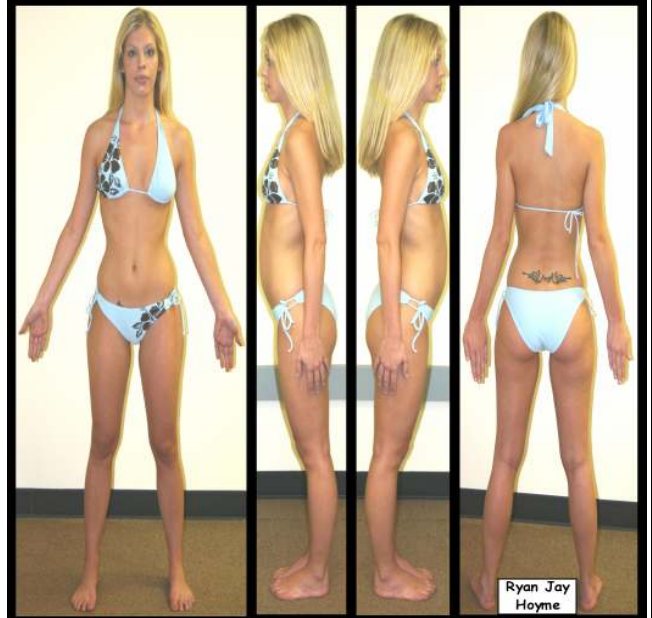
\*Is there anything else I should know about \_\_\_\_\_

I have stated all conditions that I am aware of and that this information is true and accurate to the best of my knowledge. I agree to inform my massage therapist immediately of any change in conditions as stated above. I acknowledge that this information is confidential and intended for review by fellow massage therapists; that a medical referral may be requested of me; and that "This place of business" is not held liable for the management or arising of conditions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

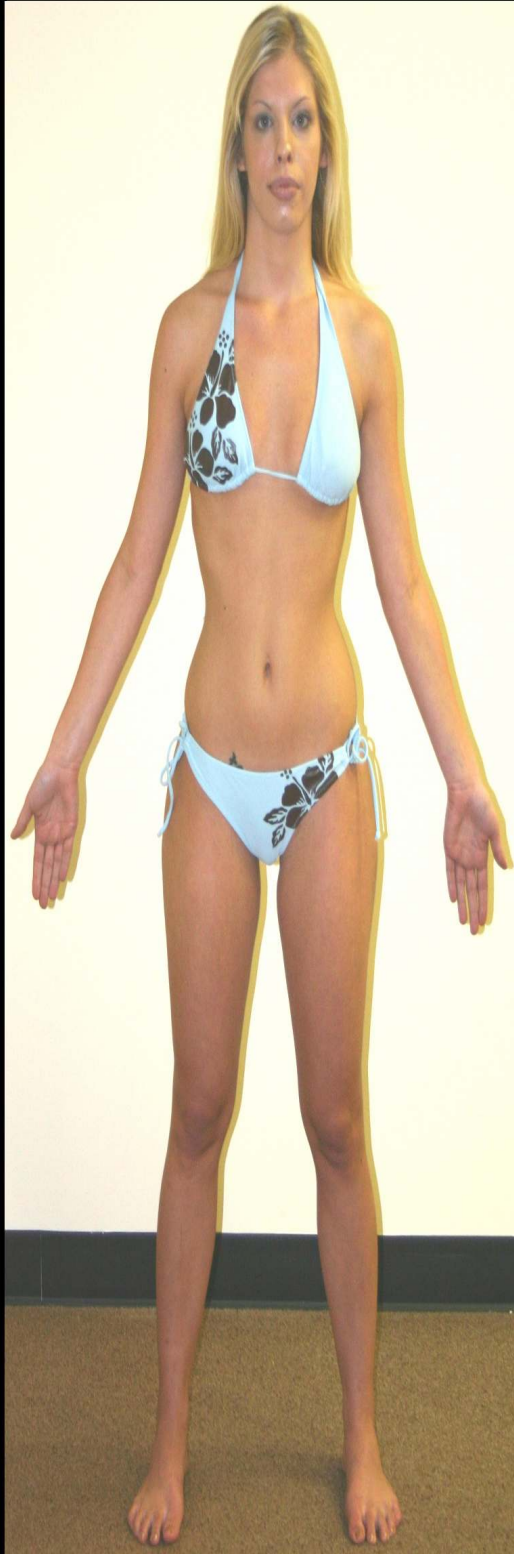
## Pain Chart

\*Mark the areas that you currently have pain



# Pain Chart

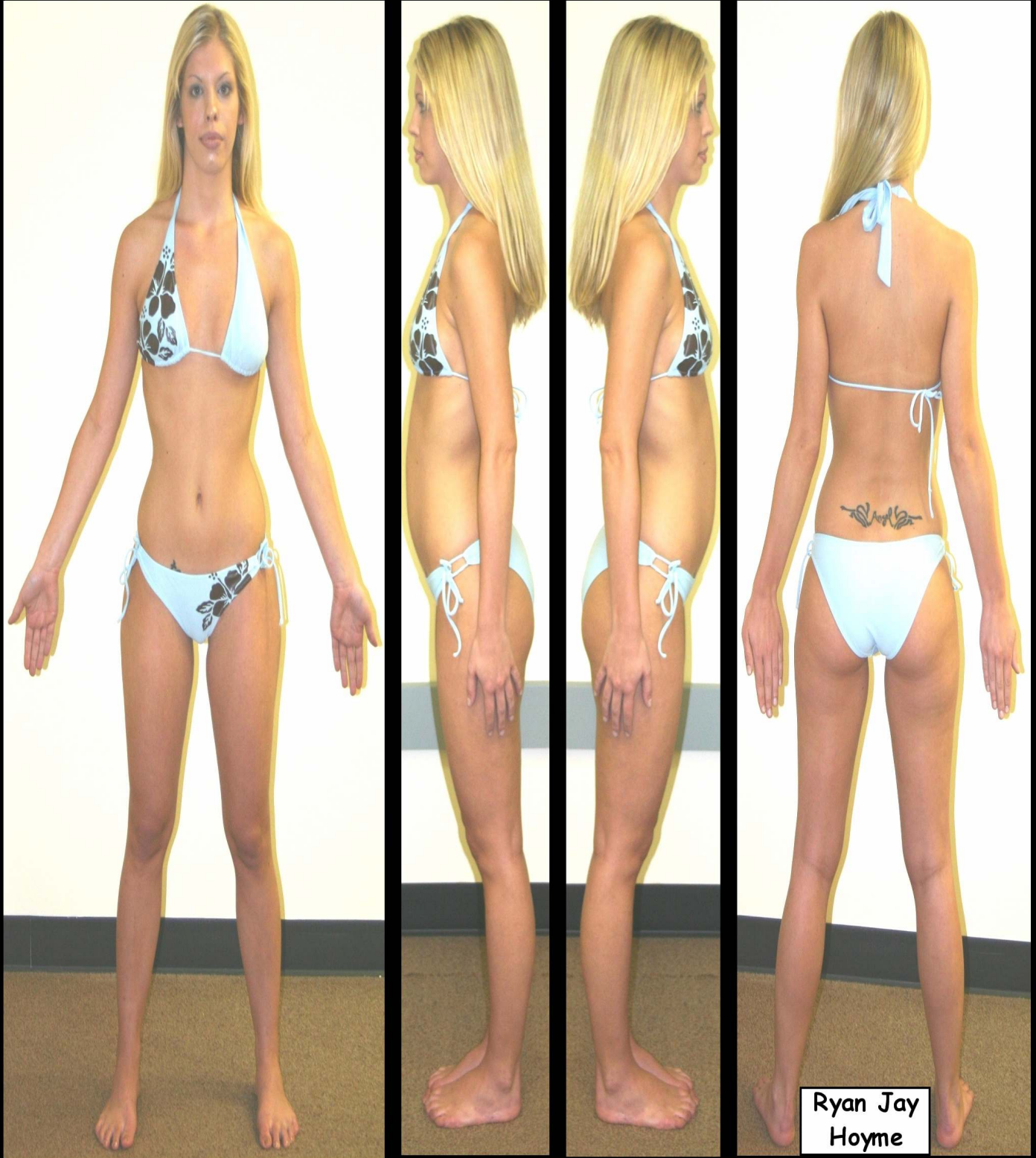
\*Mark the areas that you currently have pain



Ryan Jay  
Hoyme

# Pain Chart

○ Trigger Point ● Tender Point △ Pain × Inflamed ☆ Referred Pain  
■ Hypertonic + Improved ↓ ROM ↑ ROM



Ryan Jay  
Hoyme

Client: \_\_\_\_\_

Date: \_\_\_\_\_

**S:**

What brings you here: \_\_\_\_\_

What kind of massage do they want: \_\_\_\_\_

Occupation: \_\_\_\_\_

Health History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

Accidents: \_\_\_\_\_

Update since last massage: \_\_\_\_\_

**\*PAIN**

\*Characteristics \_\_\_\_\_ \*Symptoms \_\_\_\_\_

\*Intensity \_\_\_\_\_ \*Duration \_\_\_\_\_

\*Aggravating factors \_\_\_\_\_ \*Alleviating factors \_\_\_\_\_

**O:**

Posture: \_\_\_\_\_

Muscle tests: \_\_\_\_\_

Observation: \_\_\_\_\_

Tx goals: \_\_\_\_\_

**A:**

Tx given: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Changes: \_\_\_\_\_

Posture & Muscle testing (After Tx): \_\_\_\_\_

**P:**

Stretching: \_\_\_\_\_

Hot or Cold recommendations: \_\_\_\_\_

Liked: \_\_\_\_\_

Disliked: \_\_\_\_\_

What to perform next time: \_\_\_\_\_

\_\_\_\_\_

When to come back: \_\_\_\_\_

Ryan Jay Hoyme

# CLIENT \_\_\_\_\_

Date:

Subjective Complaints:

Objective Findings:

Treatment Given:

Date:

Subjective Complaints:

Objective Findings:

Treatment Given:

Date:

Subjective Complaints:

Objective Findings:

Treatment Given:



# CLIENT \_\_\_\_\_

Date:	S: _____
	O: _____
	A: _____
	P: _____

Date:	S: _____
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Date:	S: _____
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	P: _____





# CLIENT \_\_\_\_\_

Date:

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O: \_\_\_\_\_

A: \_\_\_\_\_

P: \_\_\_\_\_

Date:

S: \_\_\_\_\_

O: \_\_\_\_\_

A: \_\_\_\_\_

P: \_\_\_\_\_

Client \_\_\_\_\_

Date \_\_\_\_\_

○ Trigger Point ● Tender Point △ Pain ✕ Inflamed ☆ Referred Pain  
■ Hypertonic + Improved ↓ ROM ↑ ROM



Ryan Jay  
Hoyme

S: \_\_\_\_\_

O: \_\_\_\_\_

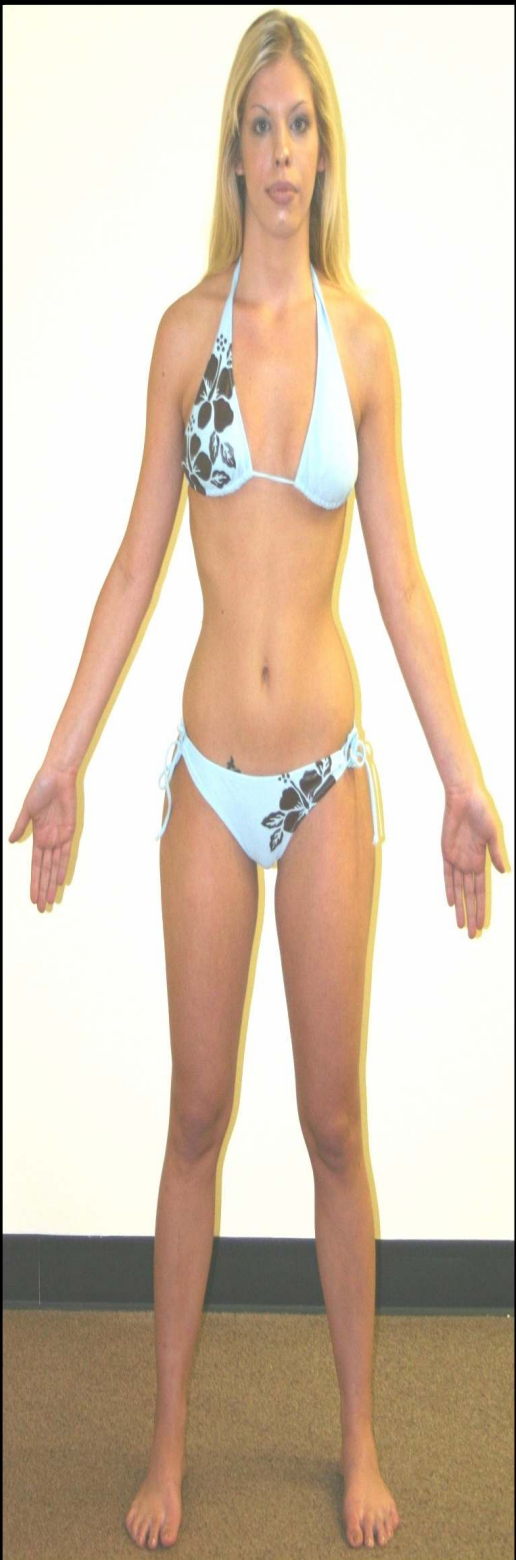
A: \_\_\_\_\_

P: \_\_\_\_\_

Client \_\_\_\_\_

Date \_\_\_\_\_

○ Trigger Point ● Tender Point △ Pain ✕ Inflamed ☆ Referred Pain  
■ Hypertonic + Improved ↓ ROM ↑ ROM



S: \_\_\_\_\_

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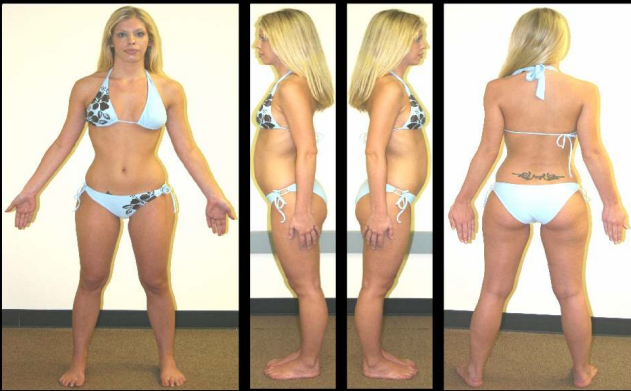


Ryan Jay  
Hoyne

Client \_\_\_\_\_

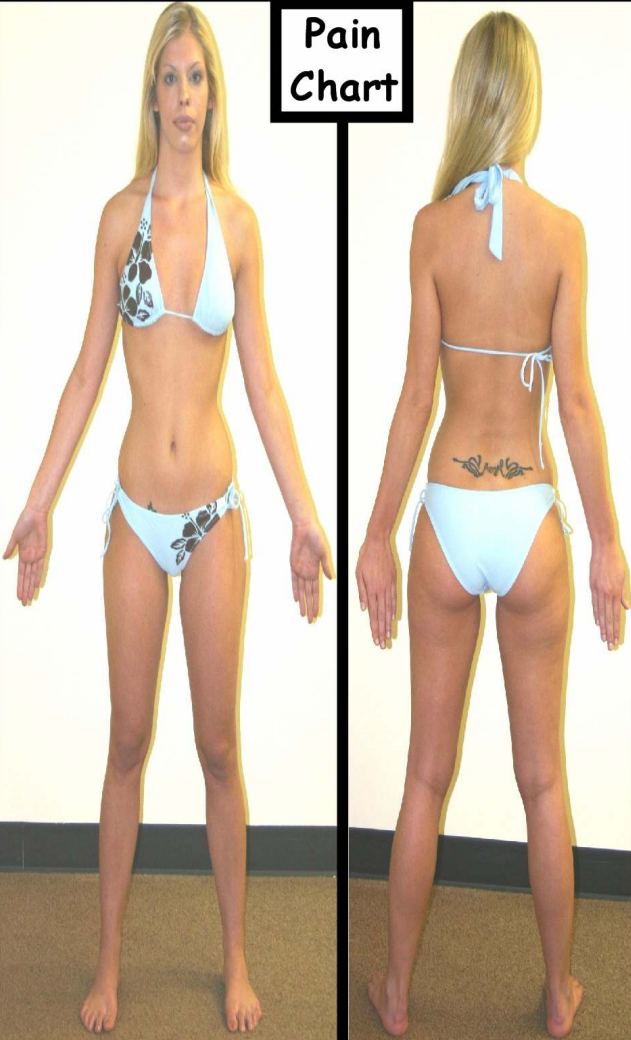
Date \_\_\_\_\_

**Posture Evaluation**



- Trigger Point   ● Tender Point   ▲ Pain
- ✕ Inflamed   ★ Referred Pain
- Hypertonic   + Improved   ↑ ROM   ↓ ROM

**Pain Chart**



S: \_\_\_\_\_

O: \_\_\_\_\_

A: \_\_\_\_\_

P: \_\_\_\_\_

Ryan Jay Hoyme

Client \_\_\_\_\_ Date \_\_\_\_\_

S: \_\_\_\_\_  
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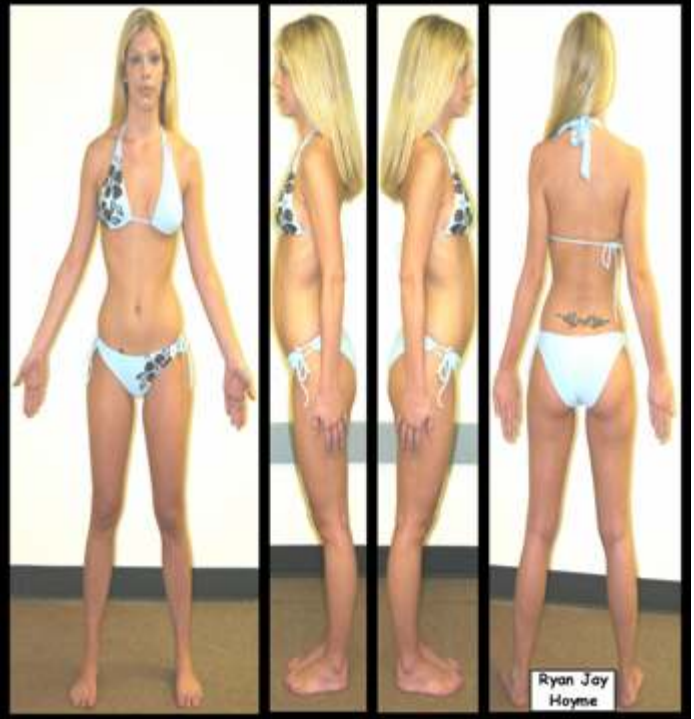
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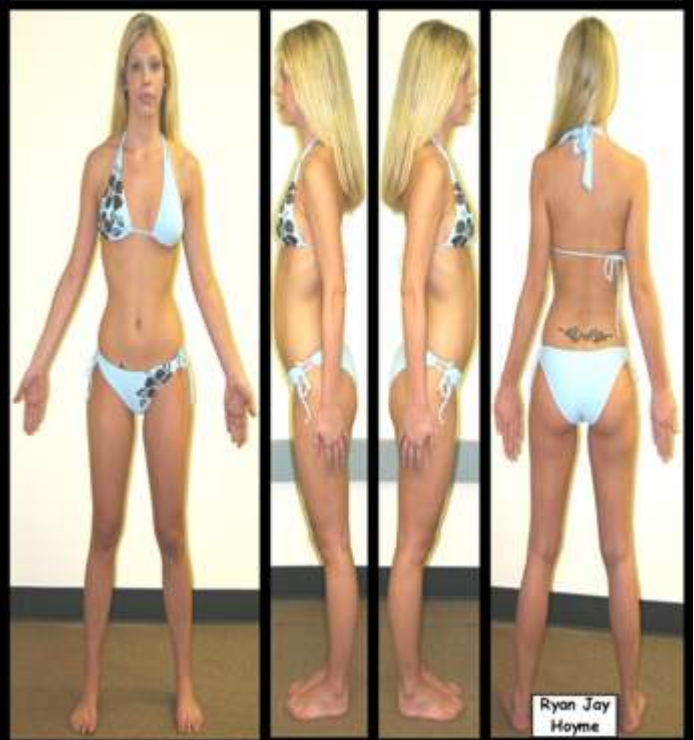
### Pain Chart

○ Trigger Point ● Tender Point △ Pain × Inflamed ★ Referred Pain  
■ Hypertonic ⊕ Improved ↓ ROM ↑ ROM



### Posture Evaluation

↑ Elevated ↓ Depressed ↙ Angled up ↘ Angled down → In ← Out



Client \_\_\_\_\_ Date \_\_\_\_\_

# SOAP NOTES

S: \_\_\_\_\_

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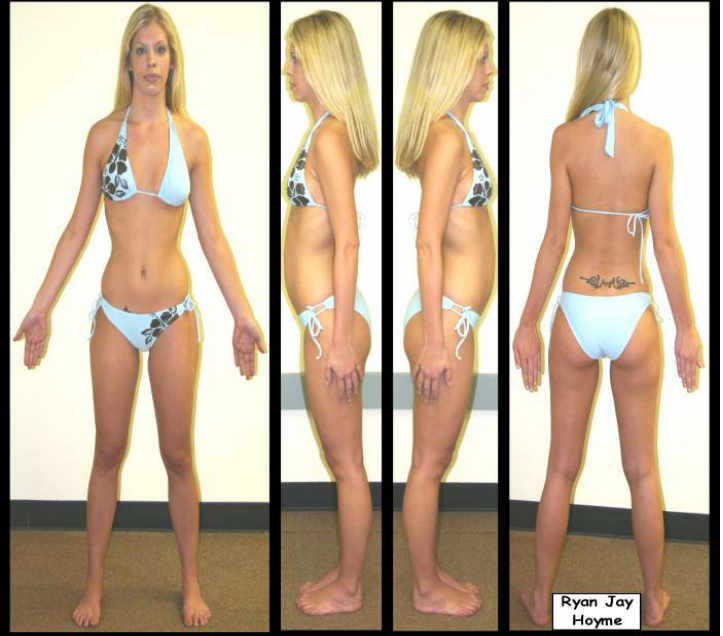
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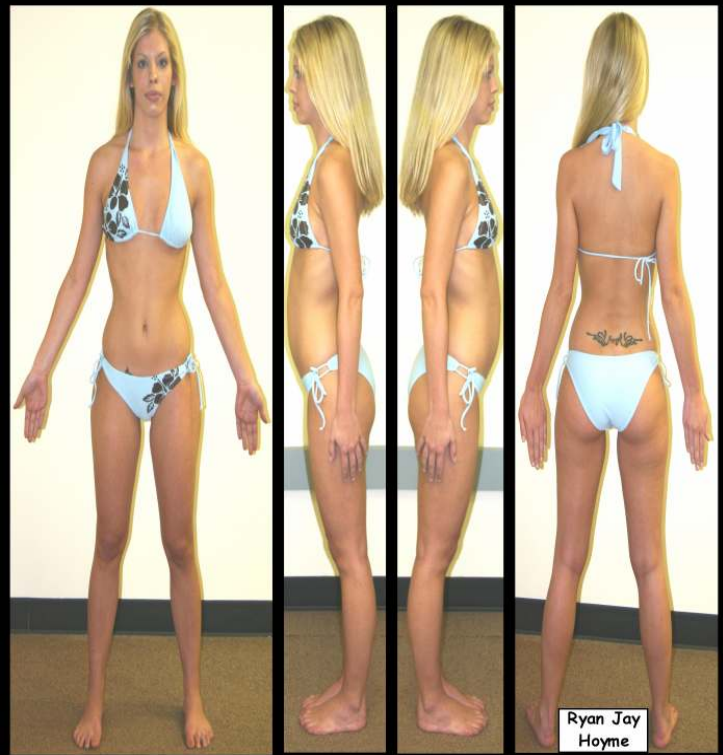
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## Pain Chart



## Posture Evaluation



Client \_\_\_\_\_ Date \_\_\_\_\_

# CARE NOTES

C: \_\_\_\_\_

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A: \_\_\_\_\_

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R: \_\_\_\_\_

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E: \_\_\_\_\_

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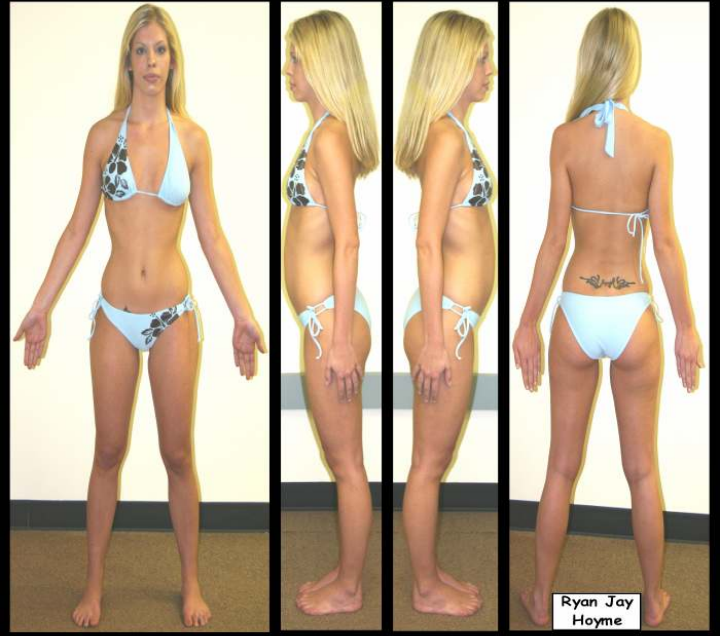
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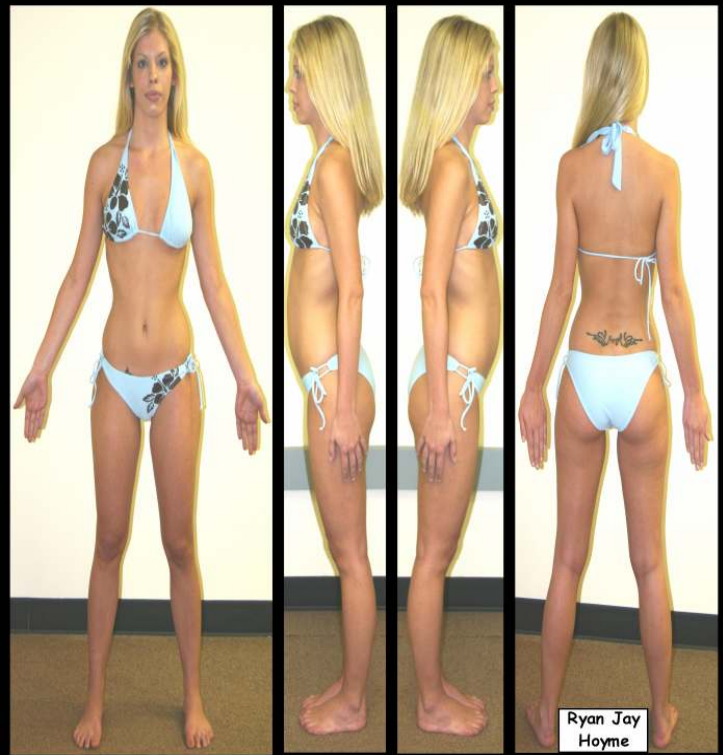
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## Pain Chart



## Posture Evaluation





# NEW CLIENT CHECKLIST

## \*Initial Call

Date: \_\_\_\_\_

Staff Member Taking the Call: \_\_\_\_\_

Client Name: \_\_\_\_\_

Account Number: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Numbers: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Who Referred the Client: \_\_\_\_\_

Reason for the Appointment: \_\_\_\_\_

Insurance Information (if applicable): \_\_\_\_\_

Client Informed of Major Policies:     Yes     No

Determine if Client Has Special Needs: \_\_\_\_\_

## \*Prior to Appointment

Date:

Staff Initials:

Welcome Packet mailed:

\_\_\_\_\_

Insurance Verified:

\_\_\_\_\_

Confirmation Call Placed:

\_\_\_\_\_

Previous Records Received:

\_\_\_\_\_

## \*First Appointment

Intake Forms Completed:

\_\_\_\_\_

Financial Arrangements Settled:

\_\_\_\_\_

## \*Client Check-Out

Fee Received:

\_\_\_\_\_

Samples and Educational Material Dispensed:

\_\_\_\_\_

Prescriptions Written:

\_\_\_\_\_

Products Sold:

\_\_\_\_\_

Next Appointment Scheduled:

\_\_\_\_\_

## \*Follow-Up

Client Check-in Call:

\_\_\_\_\_

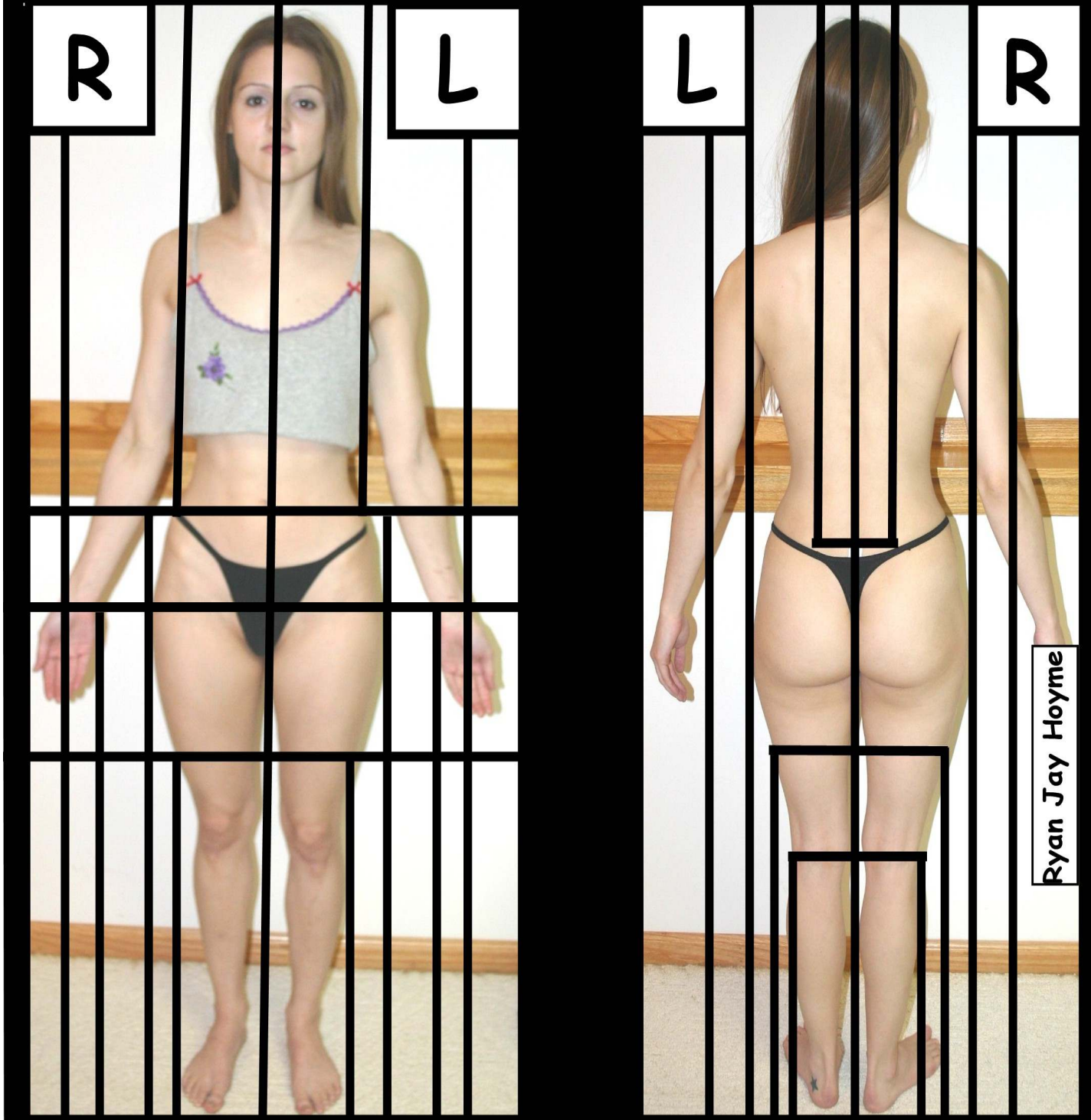
Referral Letter Sent:

\_\_\_\_\_

Progress Notes Sent:

\_\_\_\_\_

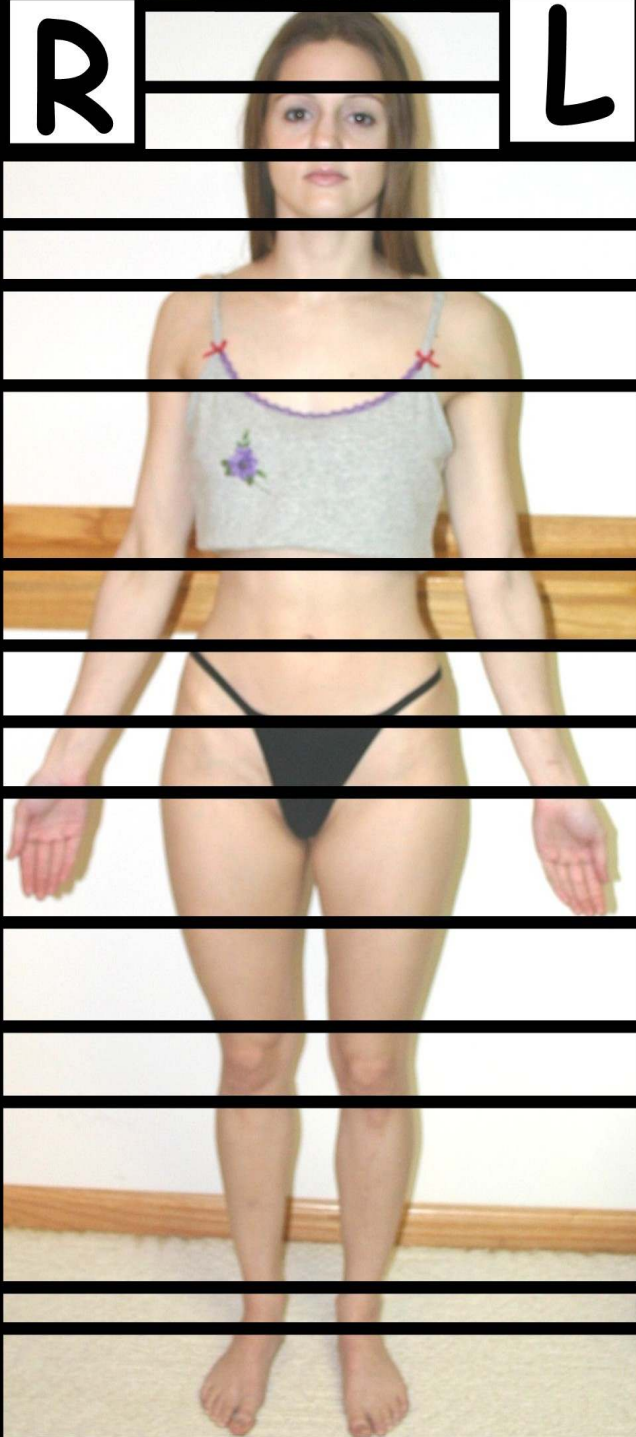
# Verticle Posture Analysis



# Horizontal Posture Analysis

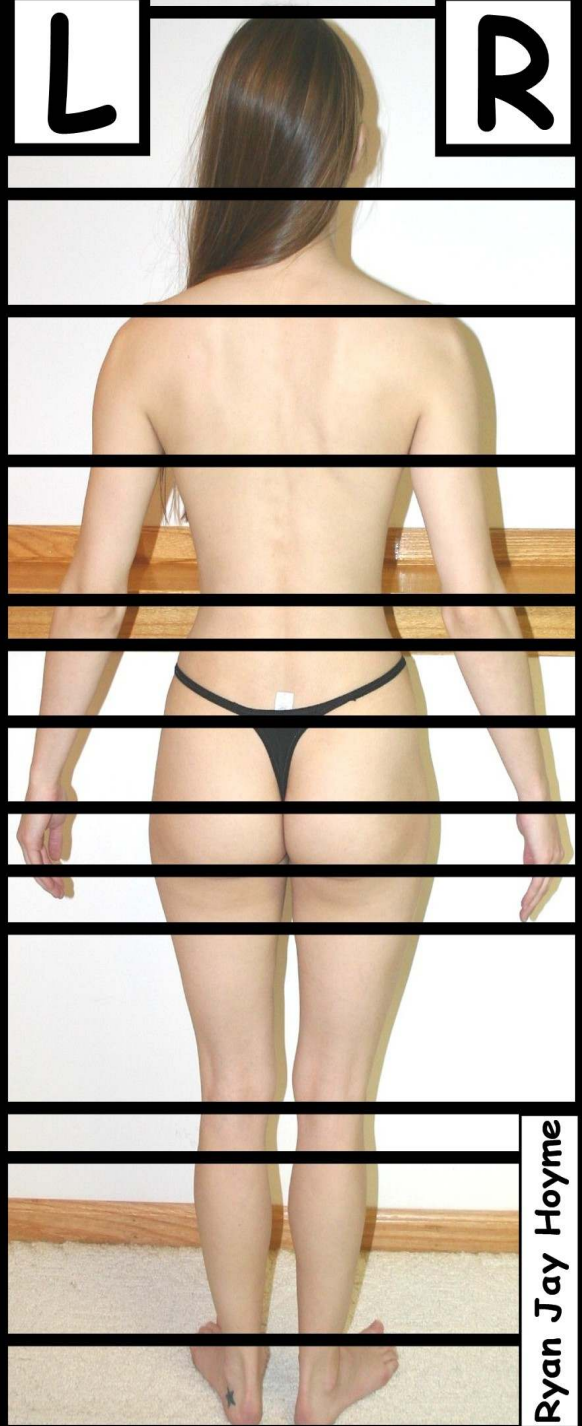
R

L



L

R



Ryan Jay Hoyme

# Posture Evaluation

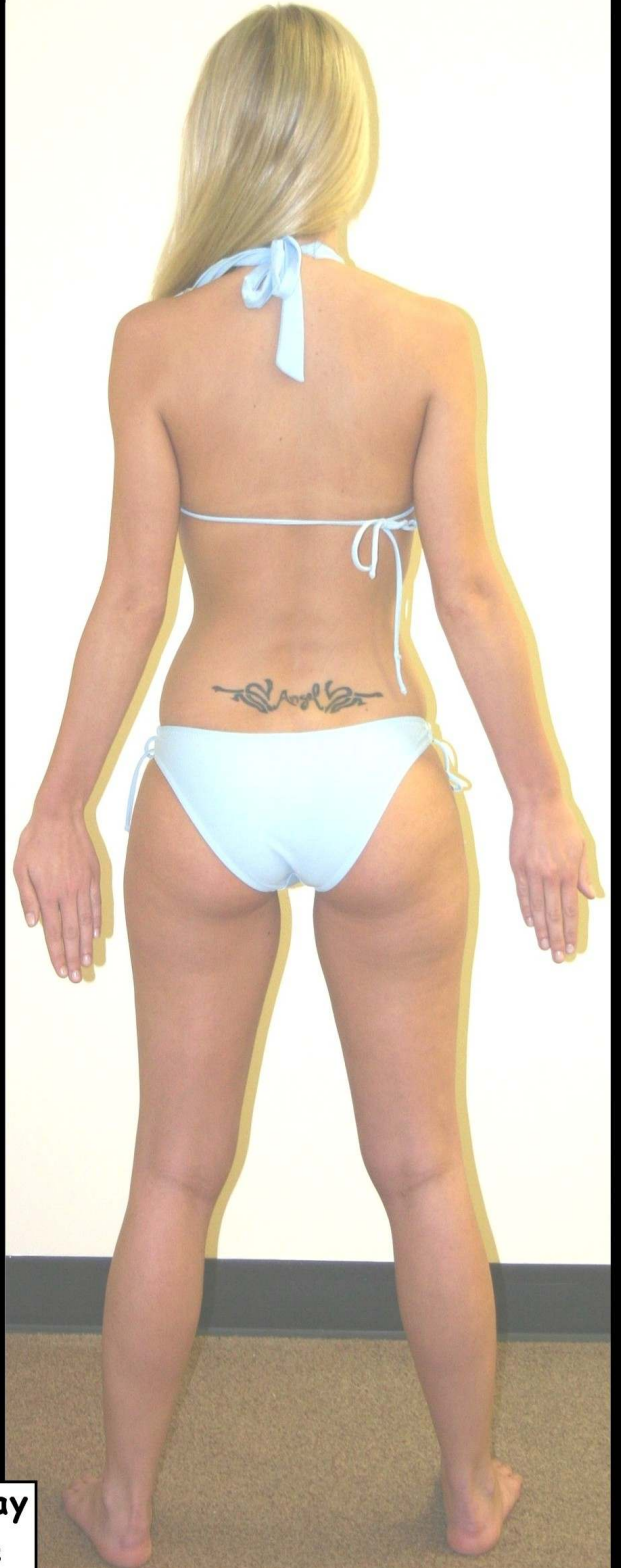
↑Elevated ↓Depressed ↙Angled up ↘Angled down →In ←Out



Ryan Jay  
Hoyme

# Posture Chart

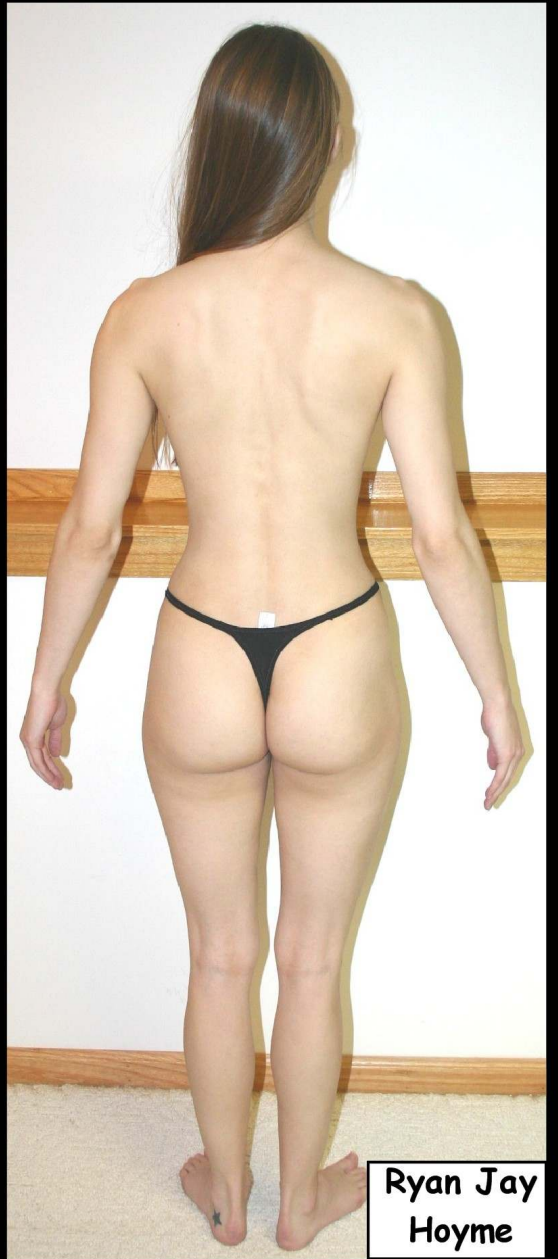
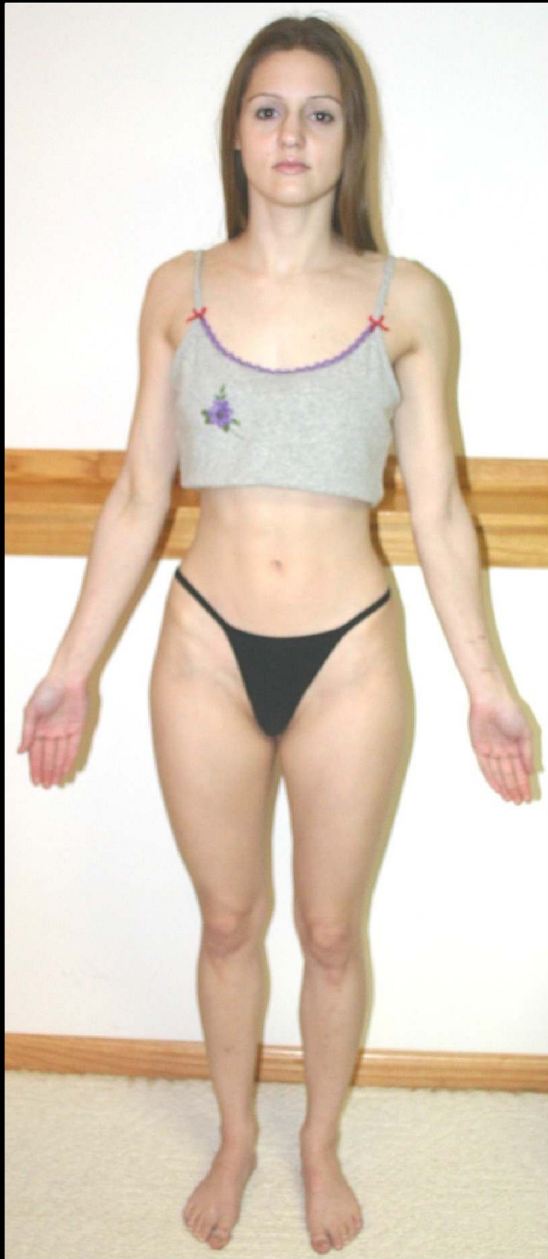
Name \_\_\_\_\_ Date \_\_\_\_\_



Ryan Jay  
Hoyme



Ryan Jay  
Hoyme



Ryan Jay  
Hoyme