Therapeutic Bodywork Solutions

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Date: ____________________

Client Sign In

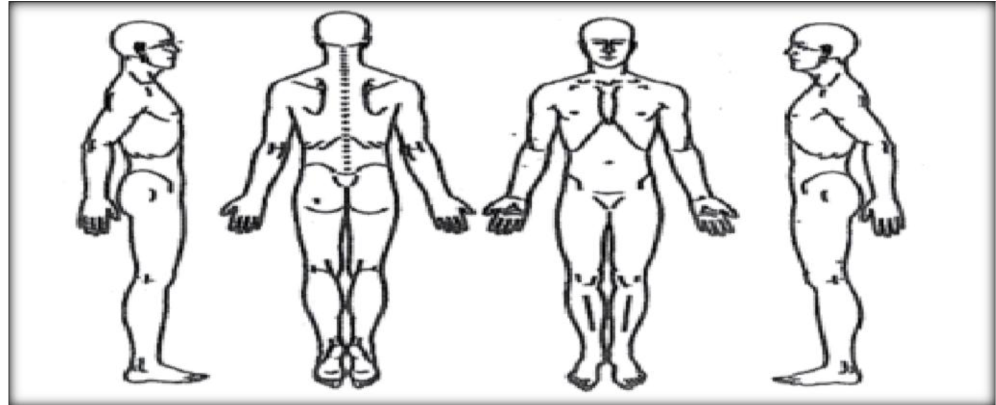
Name ____

Briefly describe your problem(s) today: ____

____

Most Stress / Pain		
S T R E SS & P AI N M E T E R		10
		9
		8
		7
		6
		5
		4
		3
		2
		1
Least Stress / Pain		

Mark with: **O** where you feel stress or pain - **X** spots to be avoided – **T** spots that are especially ticklish



Type of pain: ❑ Dull Ache ❑ Tingling ❑ Numbness ❑ Sharp ❑ Stiffness ❑ Weakness ❑ Shooting ❑ Throbbing ❑ Burning

How have you felt since your last visit (check one)? ❑ Great ❑ Much Better ❑ Better ❑ Same ❑ Worse ❑ Much Worse

Client Signature ____Date __________________

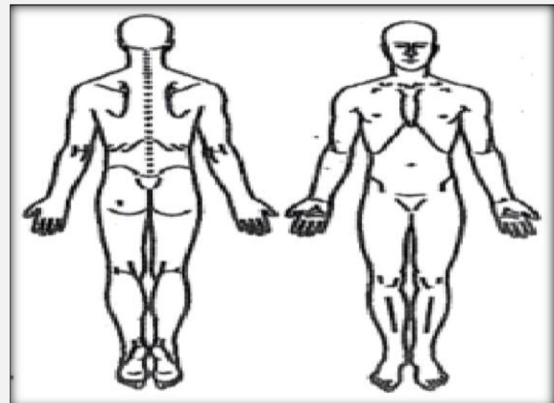
Therapist Use Only **Start Time:** ________________ **Finish Time:** ________________

Medical Referral: ❑ Yes ❑ No

Medical Diagnosis: ______________________________________

Medical recommendations: ________________________________

Area of Treatment



Code	Treatment	# Units*
99201	New client evaluation	
99211	Established client re-evaluation	
97010	Ice, Heat***	
97140	Manual Therapy	
97110	Therapeutic Exercise	
97530	Therapeutic Activities	
97124	Massage	
97014	Electric Stimulation (unattended)	
97032	Electric Stimulation (attended)	

***Units in 15 minute increments**

Response to treatment)? ❑ Good ❑ Fair ❑ Poor

Comments & recommendations: ____

Practitioner Signature ______________________________Date ________________________

Review Date: ______________________________