SOAP Notes & Consultation

Client Name & Age: _____

Number: _____ Email: _____

Therapist Name: _____

Duration of Treatment: _____

ETHEREAL MASSAGE and healing

SUBJECTIVE:

Intensity of pain (circle one):

1 2 3 4 5 6 7 8 9 10

Have you seen any other practitioners or your PCP about your condition?

_____

When did your pain first begin? _____

_____

Was their a specific incident that caused the pain? _____

_____

Pain/discomfort is brought on or made worse by? _____

_____

Pain/comfort feels better by? _____

Are you taking any current medications? _____

Please circle all that apply: Diabetes I or II Neuropathy Circulatory Conditions Pregnancy

Other: _____ Cardiovascular Conditions Digestive Conditions Cancer Other

Area of Pain

- ○ •Adhesion ○ •Hypertonicity
- ○ •Rotation ○ •Spasm
- ○ •Pain ○ •Inflammation
- ○ •Tender Point ○ •Trigger point
- ○ •Elevation ○ •Other: _____

Sensation of Pain

- ○ •Dull ○ •Cold
- ○ •Sharp ○ •Burning
- ○ •Tender ○ •Aching
- ○ •Itching ○ •Sensitive
- ○ •Cramping ○ •Tingling
- ○ •Throbbing ○ •Pressure
- ○ •Stiff ○ •Other: _____

Time | Pattern of Pain

- ○ Constant (does not change)
- ○ Intermittent (intensity doesn't change but comes and goes)
- ○ Variable (intensity changes throughout the day)

OBJECTIVE:

POSTURE ASSESSMENT

Spine:
- Normal
- Lordosis [minor moderate horrible]
- Kyphosis [minor moderate horrible]
- Scoliosis [minor moderate horrible]

Pelvis:
- Normal
- Tilt [minor moderate horrible]
- Twist [minor moderate horrible]
- Protract [minor moderate horrible]
- Retract [minor moderate horrible]

Shoulders:
- Normal
- Tilt [minor moderate horrible]
- Twist [minor moderate horrible]
- Protract [minor moderate horrible]

MODALITIES

Location:
- Full Range • Moderate Restriction
- Slight Restriction • Sever Restriction

Palpation: _____

_____

Location:
- Full Range • Moderate Restriction
- Slight Restriction • Sever Restriction

Palpation: _____

_____

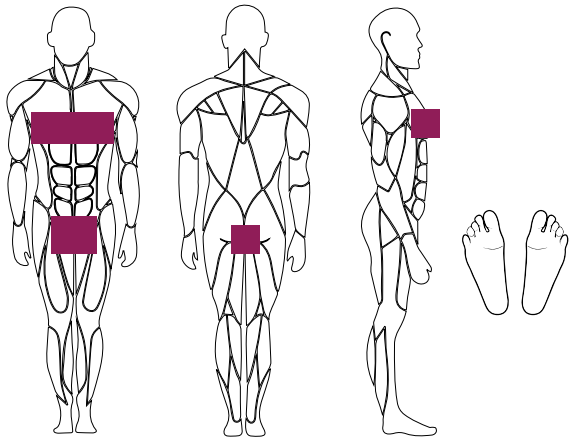
Location:
- Full Range • Moderate Restriction
- Slight Restriction • Sever Restriction

Palpation: _____

_____

Review Treatment Area

Mark areas to avoid with X. Circle areas of discomfort.



AREAS ALWAYS AVOIDED!

ASSESSEMENT:

_____

_____

_____

_____

_____

Areas Treated:
- ☐ Back ☐ Face
- ☐ Abdominals ☐ Feet
- ☐ Neck ☐ Arms
- ☐ Chest ☐ Hip Area
- ☐ Shoulders ☐ Legs
- ☐ Other _____

Treatment Method:
- ☐ Swedish
- ☐ Deep Tissue
- ☐ Trigger Points
- ☐ Hot Stone
- ☐ Stretching
- ☐ Other _____

PLAN:

Treatment Plan And Self-Care Recommendations _____

_____

_____

_____

_____

_____

_____

_____

In order to schedule an appointment, the client is required to complete a consultation beforehand. By signing this form, the client confirms that they fully comprehend the nature of Massage Therapy and agree to be draped at all times during the session in accordance with 16 Tex. Admin. Code § 117.90 (U). Requests for breast or gluteal massage before or during the session will require a separate consent form and waiver to be signed. It is also understood that either the client or massage therapist has the right to terminate the session at any time and for any reason.

_____ CLIENT SIGNATURE

_____ THERAPIST SIGNATURE

__/__/__ DATE