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## Wellness Chart

Name \_\_\_\_\_ ID#/DOB \_\_\_\_\_ Date \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

1. What are your goals for health, and how may I assist you in achieving your goals? \_\_\_\_\_

2. List typical daily activities—work, exercise, home. \_\_\_\_\_

3. Are you currently experiencing any of the following? If yes, please explain.

pain, tenderness	<input type="checkbox"/> No	<input type="checkbox"/> Yes: _____	stiffness	<input type="checkbox"/> No	<input type="checkbox"/> Yes: _____
numbness or tingling	<input type="checkbox"/> No	<input type="checkbox"/> Yes: _____	swelling	<input type="checkbox"/> No	<input type="checkbox"/> Yes: _____
allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes: _____			

4. List all illnesses, injuries, and health concerns you have now or have had in the past 3 years. (Examples: arthritis, diabetes, car crash, pregnancy) \_\_\_\_\_

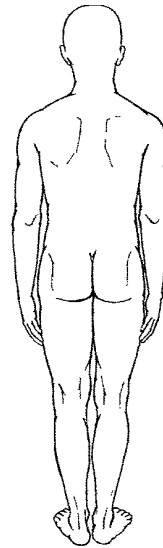
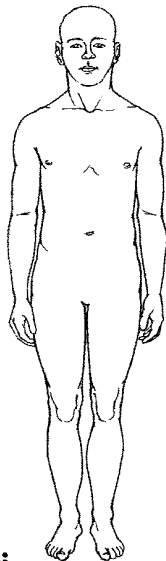
5. List medications and pain relievers taken this week. \_\_\_\_\_

6. I have provided all my known medical information. I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment. I give my consent to receive treatment.

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

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

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



**Legend:**

⊙ TP	• TeP	○ P	* Infl	≡ HT	≈ SP	initials _____
× Adh	≧ Numb	○ rot	/ elev	>< Short	↔ Long	