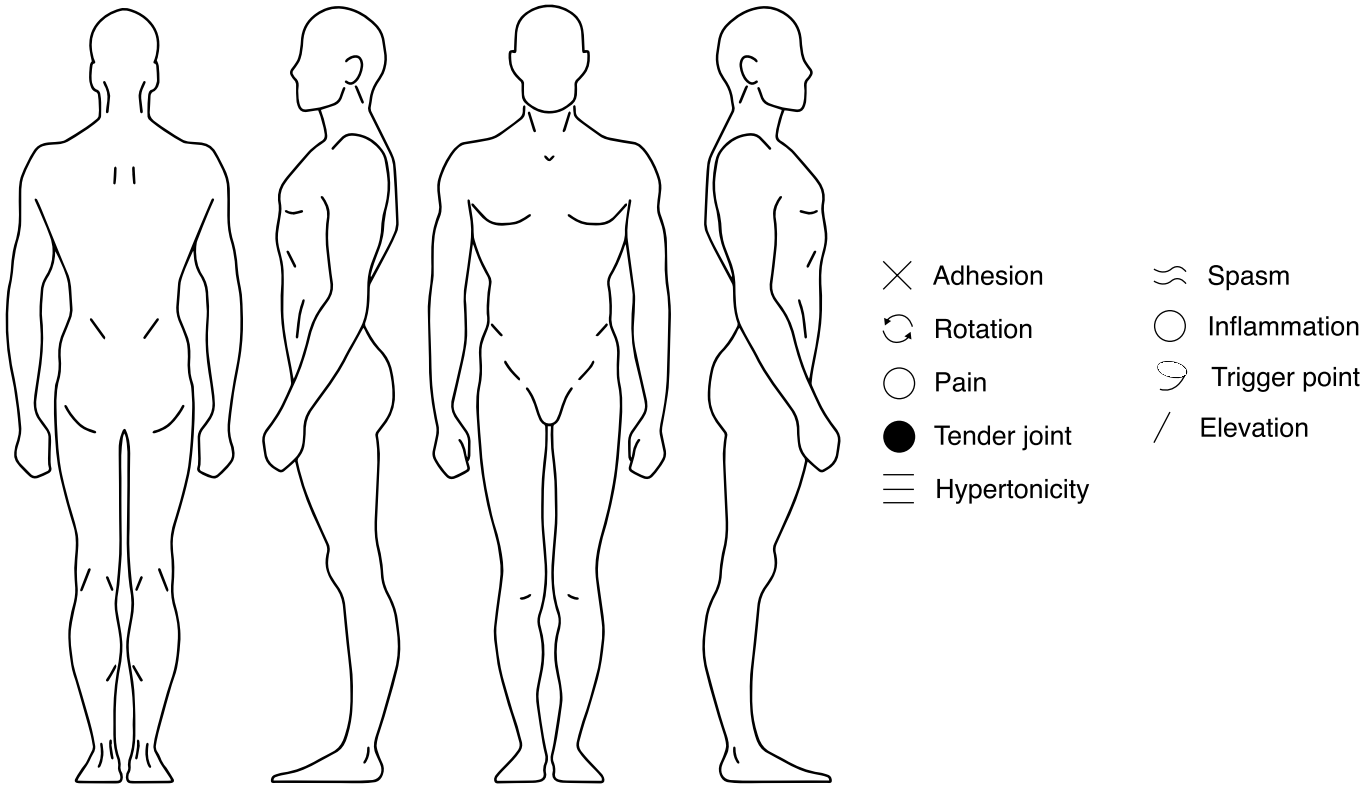
Body Assessment Form

Patient information	
First name:	**Last name:**
Date of birth:	**Gender:**

Medical history

Please list any medical conditions or health problems you have had in the past or present:

Please indicate any areas of concern by using the symbols below:



Remarks:

Clinician name:

Signature:	**Date:**