

# Body Assessment Form

**Patient information**

<b>First name:</b>	<b>Last name:</b>
<b>Date of birth:</b>	<b>Gender:</b>

**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:**

✕ Adhesion	≈ Spasm
↻ Rotation	○ Inflammation
○ Pain	⦿ Trigger point
● Tender joint	/ Elevation
≡ Hypertonicity	

**Remarks:**

**Clinician name:**

<b>Signature:</b>	<b>Date:</b>
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