

Patient name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Date: \_\_\_\_\_ day / month / year   
 Primary Phone No: \_\_\_\_\_  
 Diagnosis / Syndrome: \_\_\_\_\_  
 e-mail: \_\_\_\_\_

**1 History of the developed disease**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**2 Complaints: - General complaints**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Chief complaint at the moment of the assessment:

\_\_\_\_\_  
 \_\_\_\_\_

**3 Rate your patient's overall health**

Excellent  Good  Fair  Poor  Very Bad  Terrible  Don't Know

**4 Any of the following:**

- |  |  |
|--|--|
| <input type="checkbox"/> High/Low Blood-pressure           | <input type="checkbox"/> Haemorrhage                   |
| <input type="checkbox"/> Heart Condition                   | <input type="checkbox"/> Skin Diseases/disorders       |
| <input type="checkbox"/> Varicose Veins/Phlebitis          | <input type="checkbox"/> Epilepsy/ Seizures            |
| <input type="checkbox"/> Slipped disc/back condition       | <input type="checkbox"/> Diabetes                      |
| <input type="checkbox"/> Rheumatoid/Osteoarthritis         | <input type="checkbox"/> Asthma/Respiratory Conditions |
| <input type="checkbox"/> Abdominal/Digestive complaint     | <input type="checkbox"/> Psychiatric disorders         |
| <input type="checkbox"/> Dysfunction of the nervous system | <input type="checkbox"/> Auto-immune disorders         |
| <input type="checkbox"/> Fatal or terminal conditions      | <input type="checkbox"/> Traumatic Injury/Surgery      |
| <input type="checkbox"/> Kidney Infection                  | <input type="checkbox"/> Neuropathies                  |
| <input type="checkbox"/> Thrombosis                        | <input type="checkbox"/> Other _____                   |

**5 Medication currently: inc. dose\***

\_\_\_\_\_  
 \_\_\_\_\_

**6 Other therapies: currently and in past:**

Patient goals: short term: \_\_\_\_\_ long term: \_\_\_\_\_

Patient barriers: \_\_\_\_\_

Patient Education:  HEP  Posture  Body mechanics  Injury information  other

**8 Pain evaluation before the treatment:**

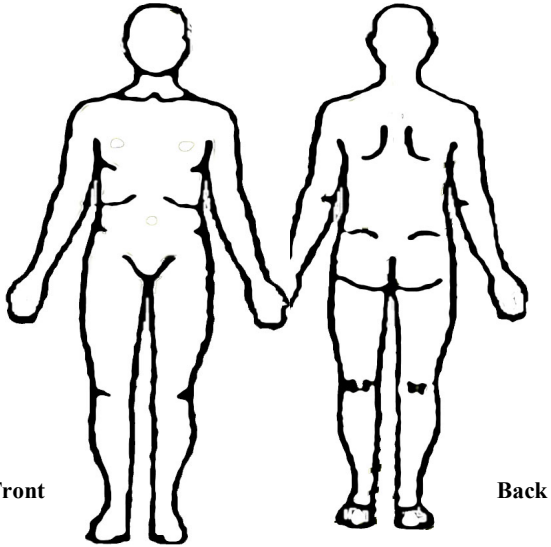
0 1 2 3 4 5 6 7 8 9 10  
No pain Pain at worst

Pain overall: \_\_\_\_\_ Right now at time of treatment Point of pain: \_\_\_\_\_

Location: \_\_\_\_\_ Elicited by: \_\_\_\_\_

	Observation			Palpation		ROM		Muscle tone	Strength	Function
	Oedema	Erythema	Rash	Tender	Hot	Limitation	Stiffness			
<b>Before</b>										
<b>After</b>										

Circle the area of **Active Sites**: On the diagram below



**Recommended treatment plan: course of treatment / frequency of treatment:**

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**Pain Quality/Description:**

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**9 Treated the following:**

• InterX assessment	• 6 trigeminal points	min
• 3:1		min
• HS(s)		min
• Local		min
• Spinal Root		min
• Complaint Region: Cervical; Thoracic; Lumbar; Sacral		min
• Dermatomes:		min
• 24 Source points		min
• Flex array: Cycle..... Location..... time.....		
• Flex array: Cycle..... Location..... time.....		
• Other:		

**10 Immediate treatment outcome:** • Pain 0 1 2 3 4 5 6 7 8 9 10  
 • Other \_\_\_\_\_ No pain Pain at worst

**11** Other modalities used: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_