Body Map

Practitioner/Clinic Name: _____

Contact Information: _____

Date: _____

Name: _____

Note the finding next to the muscle checked:
T = Tension, hypertonicity P = Pain S = Spasm I = Inflammation N = Numbness/tingling

Arm
- ☐ Biceps/Tricep Supinator ____
- ☐ Brachialis ____
- ☐ Coracobrachialis ____
- ☐ Deltoids: Ant/Lat/Post ____
- ☐ Pronator Teres ____

Hip/Leg
- ☐ Add Long/Brev Mag ____
- ☐ Biceps Femoris ____
- ☐ Gemellus Sup/Inf ____
- ☐ Gluteus Max/Med/Min ____
- ☐ Obturator Int/Ext ____
- ☐ Pectineus ____
- ☐ Piriformis ____
- ☐ Psoas Major/Iliacus ____
- ☐ Quadratus Femoris ____
- ☐ Rectus Femoris ____
- ☐ Sacrospinalis ____
- ☐ Sartorius/Gracilis ____
- ☐ Semi-Tend/Membranosus ____
- ☐ Tensor Fasiae Latae ____
- ☐ Trochanteric ____
- ☐ Vastus Int/Med/Lat ____

Chest
- ☐ Diaphragm ____
- ☐ Ext/Int Oblique ____
- ☐ Intercostals ____
- ☐ Pectoralis Major/Minor ____
- ☐ Rectus Abdominis ____
- ☐ Ribs ____
- ☐ Serratus Anterior ____
- ☐ Subclavius ____
- ☐ Transverse Abdominis ____

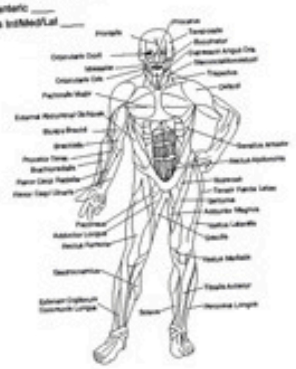
Foot
- ☐ Abd/Add Hallucis Brev ____
- ☐ Abductor Digiti Brevis ____
- ☐ Dors/Plan Interossei ____
- ☐ Flexor Digiti Minimi Brevis ____
- ☐ Flexor Digitorum Brevis ____
- ☐ Flexor Hallucis Brevis ____
- ☐ Lumbricals ____
- ☐ Quadratus Plantae ____
- ☐ Retrocalcaneal ____

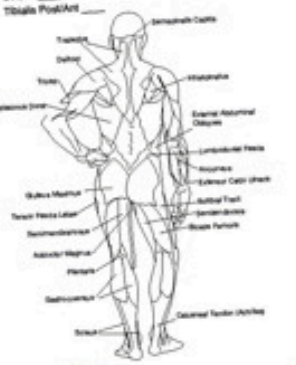
Neck
- ☐ Scalenes Anter/Med/Post ____
- ☐ Splenus Capitus ____
- ☐ Splenus Cervicus ____
- ☐ Sternocleidomastoid ____
- ☐ Supra Infra Hyoids ____

Head
- ☐ Auricularis Post/Sup ____
- ☐ Buccinator ____
- ☐ Masseter ____
- ☐ Orbicularis Oris/Occuli ____
- ☐ Pterygoid Med/Lat ____
- ☐ Transverse Nuchae ____
- ☐ Temporalis ____

Lower Leg
- ☐ Flex/Ext Digitorum Long/Bl ____
- ☐ Flex/Ext Hallucis Long ____
- ☐ Gastrocnemius ____
- ☐ Peroneus Tert/Brev/Lon ____
- ☐ Plantaris/Popliteus ____
- ☐ Soleus ____
- ☐ Tibialis Post/Ant ____

Back
- ☐ Erector Spinae ____
- ☐ Iliocostalis ____
- ☐ Infraspinatus ____
- ☐ Interspinalis ____
- ☐ Intertransversarii ____
- ☐ Latissimus Dorsi ____
- ☐ Levator Scapula ____
- ☐ Longissimum ____
- ☐ Multifidus Rotatores ____
- ☐ Quadratus Lumborum ____
- ☐ Rhomboids: Major/Minor ____
- ☐ Serratus Post/Sup/Inf ____
- ☐ Spinalis/Semispinalis ____
- ☐ Subscapularis ____
- ☐ Supraspinatus ____
- ☐ Teres Major/Minor ____
- ☐ Trapezius ____





Associated Bodywork & M...

SOAP Notes

Practitioner/Clinic Name: _____

Contact Information: _____

Client Name: _____ DOB: _____ Ins. ID#: _____

S: (Subjective) Client reported status—goals for session, symptoms, functional limitations; Physician's diagnosis or description of condition

O: (Objective) Practitioner reported findings—posture, movement, palpation; and massage/bodywork application—what you did, where you did it, for how long

A: (Assessment/Application) Client's response to treatment—less pain, more movement, etc.; quantify results using either a numerical scale, 0-10, or a value scale, Mild (L) moderate (M) or Severe (S)

P: (Plan) Recommendations for self-care and plan for future care

S: _____
O: _____
A: _____
P: _____
Date: _____ Duration: _____

S: _____
O: _____
A: _____
P: _____
Date: _____ Duration: _____

S: _____
O: _____
A: _____
P: _____
Date: _____ Duration: _____

S: _____
O: _____
A: _____
P: _____
Date: _____ Duration: _____

Key: Symbols for figures
Pain ✪
Stiffness/tension, ie
Spasm ≈
Adhesion/Scar tissue X
Inflammation ✪
Elevation or depression /
Rotated ↻ or ↺

Key: Abbreviations
R = right
L = left
BL = bilateral
ROM = range of motion
XFF = cross fiber friction
P = pain
M = massage
HA = headache
< = less than
> = greater than

MEMBER
Associated Bodywork & Massage Professionals

Health Information

(page 1 of 2)

Practitioner/Clinic Name: _____

Contact Information: _____

Date: _____

Client Contact Information
Client Name: _____ Gender: _____
Date of Birth: _____
Address: _____
Phone: _____
Referred by: _____
Emergency contact: _____ Phone: _____
Physician/health-care Provider name: _____ Phone: _____
Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes ☐ No ☐
Do you have a physician referral/prescription? Yes ☐ No ☐ If yes, please complete the Billing Information form.
Are you seeking insurance reimbursement? Yes ☐ No ☐
Type of insurance coverage for this claim: Car Collision Worker's Compensation Private Health

Massage Information
Have you ever received professional massage/bodywork before? Yes ☐ No ☐
How recently? _____
What types of massage/bodywork do you prefer? _____
What kind of pressure do you prefer? Light Medium Firm
What are your goals/expected outcomes for receiving massage/bodywork? _____

How do you feel today? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.): _____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No
Explain: _____

List the medications you currently take: _____

Are you wearing contacts? Yes ☐ No ☐
Are you wearing dentures? Yes ☐ No ☐
Are you wearing a hairpiece? Yes ☐ No ☐
Are you pregnant? Yes ☐ No ☐

Associated Bodywork & Massage Profe...

...ening Questionna...

(page 1

Contact Information: _____

Client Information
Client Name: _____
Preferred phone number: _____ Date: _____
Email address: _____ Best time to call: _____
Preferred form of communication: _____

Massage Information
How did you hear about me? (referral, Facebook, etc.) _____
Is this a gift certificate? Yes ☐ No ☐
Massage history:
Have you had a massage/bodywork before? Yes ☐ No ☐
Frequency: _____
Types of massage/bodywork received: _____
Preferred types of massage: _____

Reasons for seeking massage? (relaxation, injury, etc.)
_____
Description of injury/health condition:
_____
Possible complications/medications:
_____
Expected outcomes (functional improvement, symptom relief, wellness):
_____
Typical activities of daily living (affected by condition?):
_____
Occupation (affected by condition?):
_____

Are you seeking insurance reimbursement? Yes ☐ No ☐
Car collision/personal injury? _____
On-the-job injury? _____
Private health insurance? _____
Do you have a physician referral with diagnosis codes? _____

Let clients know if you provide billing services, and if so, for what types of claims, or if you will simply provide receipts and/or copies of records for them to submit for reimbursement. Let clients know a physician referral demonstrating medical necessity is required for insurance reimbursement/health savings account reimbursement regardless of who submits bills.

Best times for massage: _____

MEMBER
Associated Bodywork & Massage Professionals