TOUCH of
Intuition Massage

PATIENT PROGRESS

Patient Name: ____ Date of Birth: _______________

1. After your last visit, how long did you feel better? ____

2. Compared with how you were feeling before your last visit, how are you feeling today?

   Better Worse Same

3. Since your last treatment have you experienced any of the following: Stress Headaches

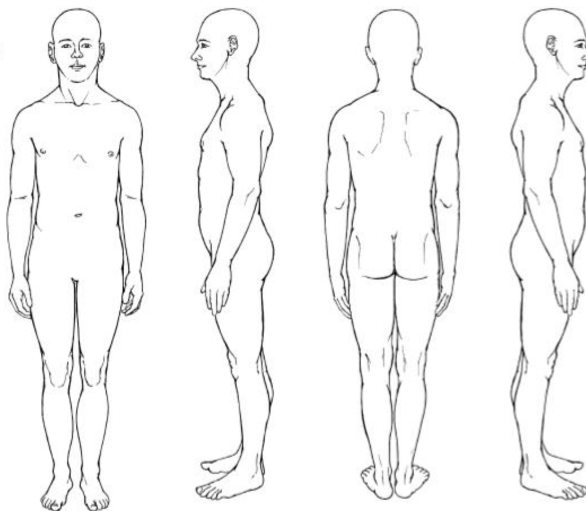
   Neck Pain Shoulder Pain Back Pain Hip/Buttock Pain Extremity

What form of Pain? Tingling Numbness Stiffness Spasms Aching Stabbing

4. Are you symptoms… Constant Intermittent (Daily) Occasional (Weekly)

5. On a scale of 1-10 rate the severity of your symptoms:

   1 2 3 4 5 6 7 8 9 10



____ _______________ Time in _________
Patient (or Gaurdian's) Signature Date Time out _________