Elk Grove Healing Massage

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www.eghealingmassage.com

MASSAGE SOAP NOTE

Client Name: _____ Date: _____

Therapist: _____ Session #: _____

Date of Birth: _____ Time In: _____ Time Out: _____

S – SUBJECTIVE

Chief Complaint / Reason for Visit: _____

Pain Level (0-10): Before Treatment: _____ After Treatment: _____

Quality of Pain / Symptoms: _____

Changes Since Last Visit / Additional Comments: _____

O – OBJECTIVE

Observation / Posture: _____

Palpation / Findings: _____

Muscle Tension / Tightness: _____

Tender Points / Restrictions: _____

Range of Motion (ROM):

☐ WNL ☐ Limited ☐ Painful

Comments: _____

A – ASSESSMENT

Assessment / Clinical Impression: _____

Areas Treated: _____

Client Response to Treatment: _____

P – PLAN / TREATMENT

Treatment Goals: _____

Massage Techniques Used: _____

Pressure: ☐ Light ☐ Moderate ☐ Deep Duration: _____

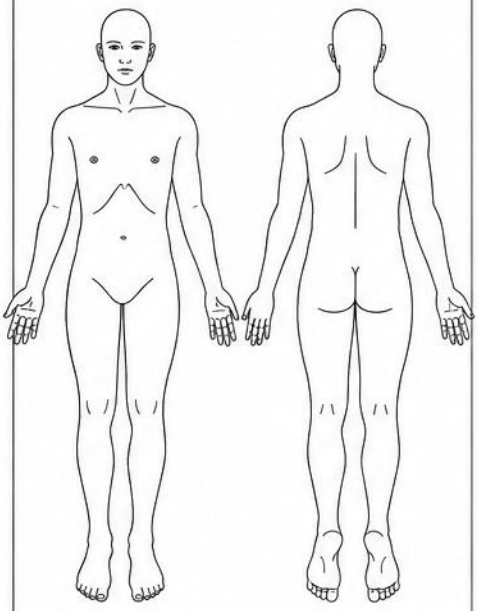
Home Care / Recommendations: _____

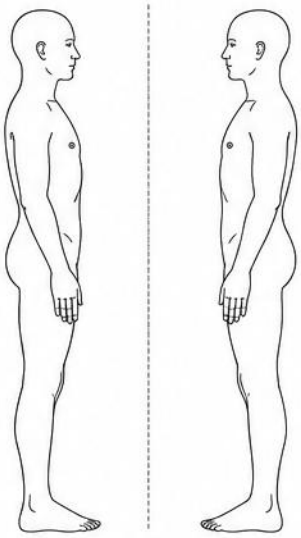
Plan for Next Visit: _____

Therapist Signature: _____ Date: _____

Client Signature: _____ Date: _____

MARK AREAS OF TENSION / PAIN





Please use the symbols below:

- X = Pain
- // = Tightness
- ● = Trigger Point
- ~~~ = Numbness / Tingling
- ○ = Other