

Body Chart

Patient information

Name:

Gender:

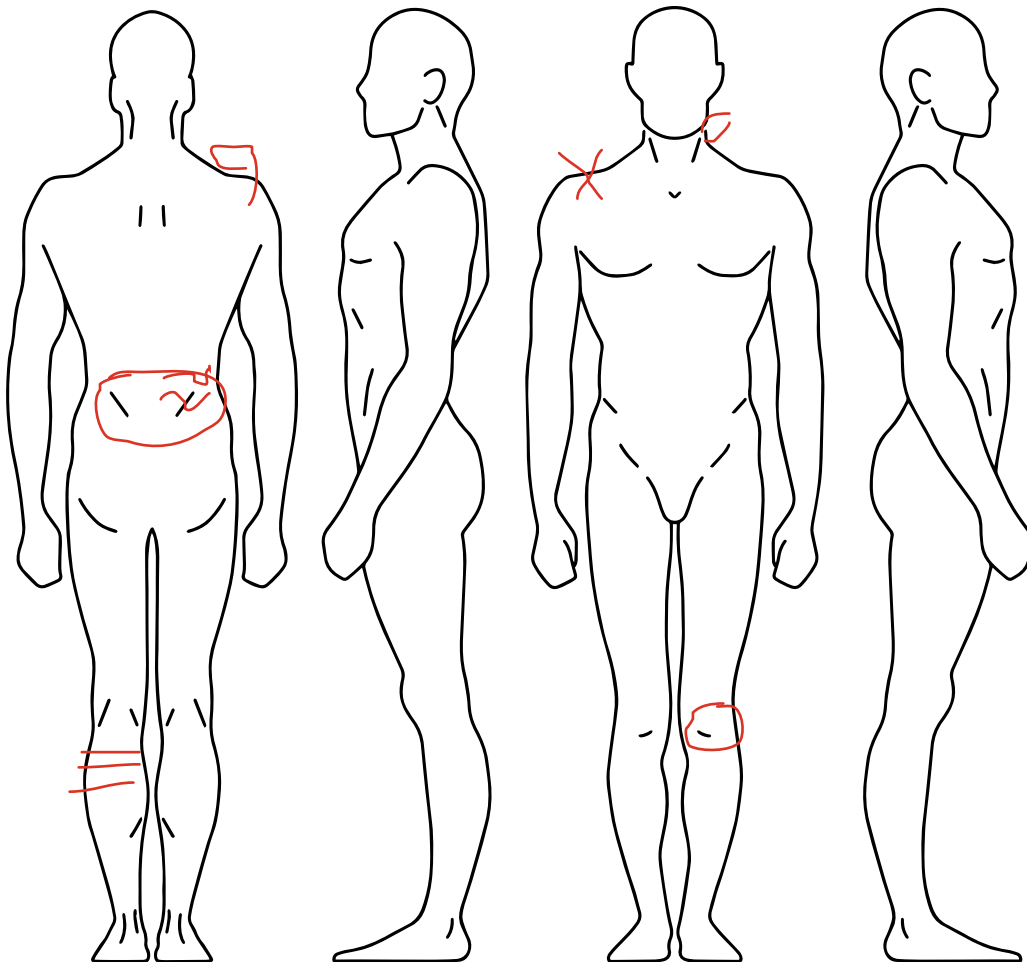
Date of birth:

Contact number:

Address:

Medical history:

Please indicate or mark any area of discomfort:



✕ Adhesion

↻ Rotation

○ Pain

● Tender joint

≡ Hypertonicity

≈ Spasm

○ Inflammation

⊖ Trigger point

/ Elevation

Body part	Observations or issues
Head	
Eyes	
Ears	
Nose	
Mouth/throat	
Neck	
Chest	
Abdomen	
Back	
Arms and hands	
Pelvis/genitals	
Legs and feet	

Summary of findings

Healthcare provider information

Doctor's name:

Doctor's signature:

License ID or no.:

Date:

Contact information: