



BOWEL MOVEMENTS   
 URINATION

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

**TODAY'S CONDITIONS AND SYMPTOMS**

I received the following BODYWORK today: \_\_\_\_\_

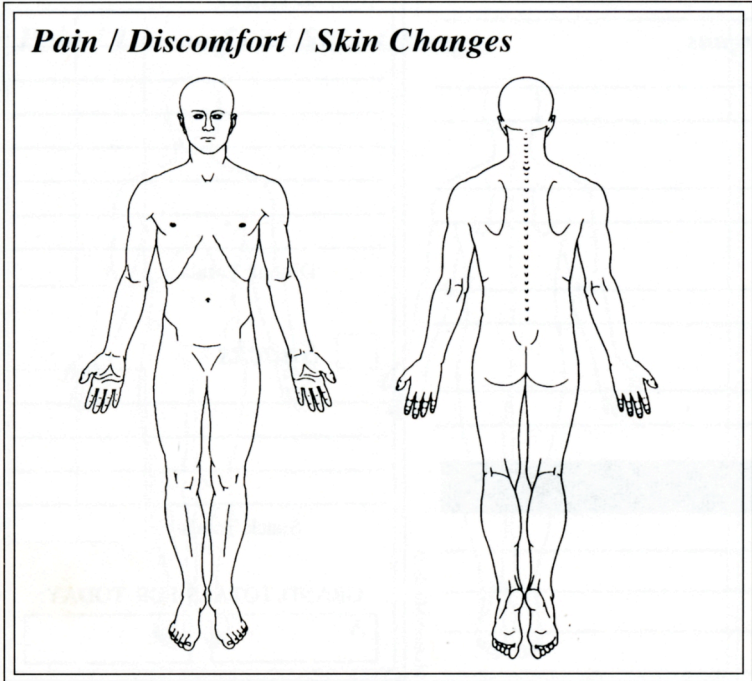
My ENERGY/FATIGUE level is: \_\_\_\_\_

My PAIN level and locations are:

1. Mild
2. Moderate
3. Severe
4. Very Severe
5. Worst Possible

Mark the area where the pain occurs with the number which corresponds to the intensity of the pain.

In general, today I felt:  
 Good  Fair  Poor



**COMMENTS**

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Did you EXPERIENCE SYMPTOMS in any of the following areas today? Explain on the lines below.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Ears / Eyes / Nose | <input type="checkbox"/> Arms / Hands       | <input type="checkbox"/> Hips / Legs / Feet   |
| <input type="checkbox"/> Mouth / Throat     | <input type="checkbox"/> Chest / Heart      | <input type="checkbox"/> Male / Female Organs |
| <input type="checkbox"/> Head / Neck / Back | <input type="checkbox"/> Respiratory System | <input type="checkbox"/> Skin                 |
| <input type="checkbox"/> Shoulders          | <input type="checkbox"/> Digestive System   | <input type="checkbox"/> Other                |

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ENVIRONMENTAL FACTORS: \_\_\_\_\_

MENTALLY I feel ... \_\_\_\_\_

EMOTIONALLY I feel ... \_\_\_\_\_

SPIRITUALLY I feel ... \_\_\_\_\_

