

Patient's Name: _____

Age _____ Weight _____ Height _____

Bra Size _____

Symptoms:

Upper Back Pain _____

Lower Back Pain _____ Shoulder Grooving _____

Neck Pain _____ Rashes under Breasts _____

Shoulder Pain _____ Restrictions of Physical activities _____

Other: _____

How long have these symptoms been present? _____

How do these symptoms interfere with your daily activities? _____

Have you ever seen another doctor for this problem? Y N

Name of Doctor: _____

Have you ever had x-rays taken on any of the following? back _____ neck _____ shoulder _____

When where these x-rays taken? _____

Pain relief measures: (pain medication, muscle relaxers, creams, heat, etc.)

Have you ever attended Physical Therapy in regards to your symptoms? Y N

When? _____

Are you currently attempting to lose weight? Y N

What measures are you taking? _____

Please list the age of all children: _____

Have you breastfed in the past? Y N

Is there any history of breast cancer in your family? Y N

If Yes, who? _____