DAO NEEDLE THERAPY EVALUATION FORM

CLIENT NAME: _____

DATE EVALUATED: _____ / _____ / _____ PREVIOUS EVALUATION: _____ / _____ / _____

CHIEF COMPLAINT: _____

_____

_____

MMT

DEF / EXC

1. _____ / _____
2. _____ / _____
3. _____ / _____
4. _____ / _____
5. _____ / _____

ROM

PASSIVE / ACTIVE

1. _____ / _____
2. _____ / _____
3. _____ / _____
4. _____ / _____
5. _____ / _____

FUNCTIONAL TESTS

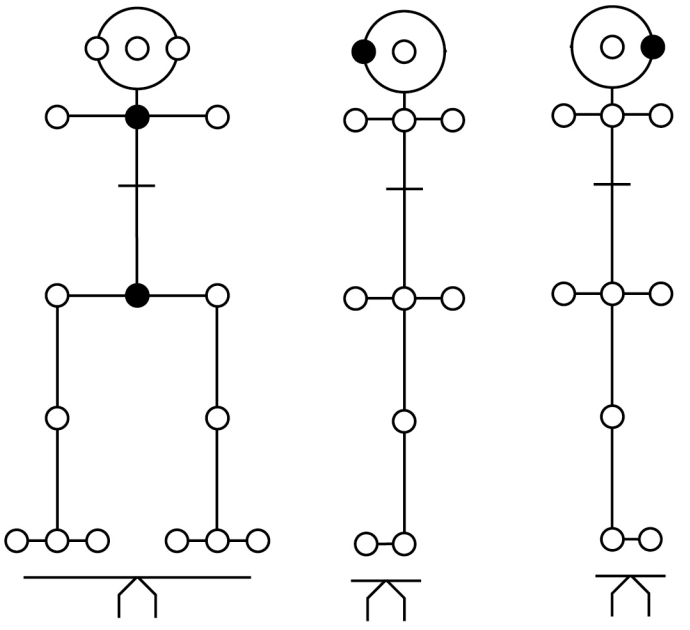
1. _____
2. _____
3. _____
4. _____
5. _____

FASCIAL LINE / MERIDIAN

1. _____ / _____
2. _____ / _____
3. _____ / _____
4. _____ / _____
5. _____ / _____

POSTURAL ASSESSMENT

FRONT VIEW LEFT VIEW RIGHT VIEW



PALPATION ASSESSMENT

FRONT BACK