

Name:		Age:		
			nt Bra Size:	
1. Do you have any of t	he following: (Please	check all that appl	y)	
☐ Breast Masses	☐ Breast Pain ☐ Br	east Asymetry	☐ Bra Strap Indentation	
☐ Poor Posture	☐ Neck Pain ☐ Sh	oulder Pain	☐ Lower Back Pain	
☐ Upper Back Pain	☐ Nerve Compression	n 🗆 Headaches	☐ Tingling of hands/arms	
2. Do you have difficult	y finding properly fitt	ing clothes as a re	sult of the size of your breas	ts? □ Yes □ No
3. Do you limit your ph	ysical activities as a re	sult of the size of	your breasts?	☐ Yes ☐ No
If YES, which activities	(working out, activitie	s of daily living):		
breasts?			ack pain related to the size o	fyour
☐ Chiropractor ☐ Orth	opedic Surgeon 🗆 Pl	ysical Therapist	☐ Acupuncturist	
5. Length of Treatment				_
6. Do you regularly take	e any of the following	to assist with bac	k pain dues to the size of you	ır breasts?
□ Advil □ Ibuprofen □ Naproxen □ Aspirin □ Diclofenac □ Other:				
7. Date of your last ma	mmogram:			
FOR OFFICE USE ONLY:				
		Baker  I - Normal  II - Palpable, min not visible  III - Visible, mod feasily palpab  IV - Painful, hard,  Amount of tiss  Lt:	irm, III - NAC below le <b>Pseudo</b> - NAC c	breast IMF and breast above IMF/