

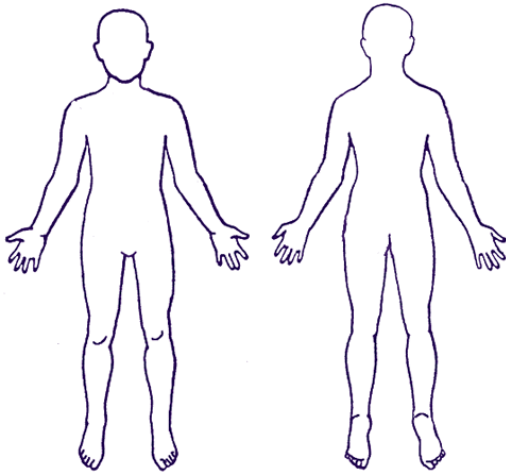


MBC Somatic Sensation Check-In

Name: _____ Date: _____

Email/Phone: _____

1. On the diagram, shade in the areas where you feel discomfort. Put an X on the area that hurts the most.



2. Circle the one number that describes how, during the past 24 hours, discomfort, tension, concern, etc. has interfered with your:

A. General Activity (Work, Exercise)
 0 1 2 3 4 5 6 7 8 9 10
 Does not Completely Interferes
 Interfere Interferes

B. Mood
 0 1 2 3 4 5 6 7 8 9 10
 Does not Completely Interferes
 Interfere Interferes

C. Walking Ability
 0 1 2 3 4 5 6 7 8 9 10
 Does not Completely Interferes
 Interfere Interferes

Date: _____

D. Relations with other People
 0 1 2 3 4 5 6 7 8 9 10
 Does not Completely Interferes
 Interfere Interferes

E. Sleep
 0 1 2 3 4 5 6 7 8 9 10
 Does not Completely Interferes
 Interfere Interferes

F. Enjoyment of Life
 0 1 2 3 4 5 6 7 8 9 10
 Does not Completely Interferes
 Interfere Interferes

G. Ability to Concentrate
 0 1 2 3 4 5 6 7 8 9 10
 Does not Completely Interferes
 Interfere Interferes

H. Appetite
 0 1 2 3 4 5 6 7 8 9 10
 Does not Completely Interferes
 Interfere Interferes

I. Sexual Activity
 0 1 2 3 4 5 6 7 8 9 10
 Does not Completely Interferes
 Interfere Interferes

J. Ability to Remain Emotionally Present
 0 1 2 3 4 5 6 7 8 9 10
 Does not Completely Interferes
 Interfere Interferes

K. Other: _____
 0 1 2 3 4 5 6 7 8 9 10
 Does not Completely Interferes
 Interfere Interferes

* To better understand your results and more information on Somatic Therapy at MBC contact our Somatic Practitioners:

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