Please fill out this form completely and legibly. Leave nothing blank.
If something does not apply, write "N/A" on the line.

Personal Contact Information **Today's Date** _____

Name_____ Age_____Date of Birth _____

Address _____ City _____ State _____Zip Code _____

Sex (Circle one): M F Employer _____

Contact Phone _____ Occupation _____

Email _____

Marital Status (Circle one): Single Partnered Married Divorced Widowed

Emergency Contact: Name _____Phone _____

Relationship to Patient _____

Medical History

Do **You** have any history of (Check all that apply):

❏ Skin conditions ❏ Cancer ❏ Stroke ❏ Injury

❏ Headaches ❏ Low blood sugar ❏ Low blood pressure ❏ High blood pressure

❏ Concussion ❏ Numbness or Tingling ❏ Arthritis ❏ Vericose Veins

❏ Allergies _____

❏ Autoimmune disease _____

❏ Other _____

List all medications, vitamins and supplements that you are currently taking: _____

_____

_____

Are you pregnant or trying to become pregnant? ____No __ Yes: Due date _____

History of Present Injury or Injuries

Describe the symptoms that you are experiencing, their location(s), and types of pain:_____

_____

_____

_____

_____

When did you first notice these symptoms?_____

Has this happened before? (Circle one) Yes No If Yes, When? _____

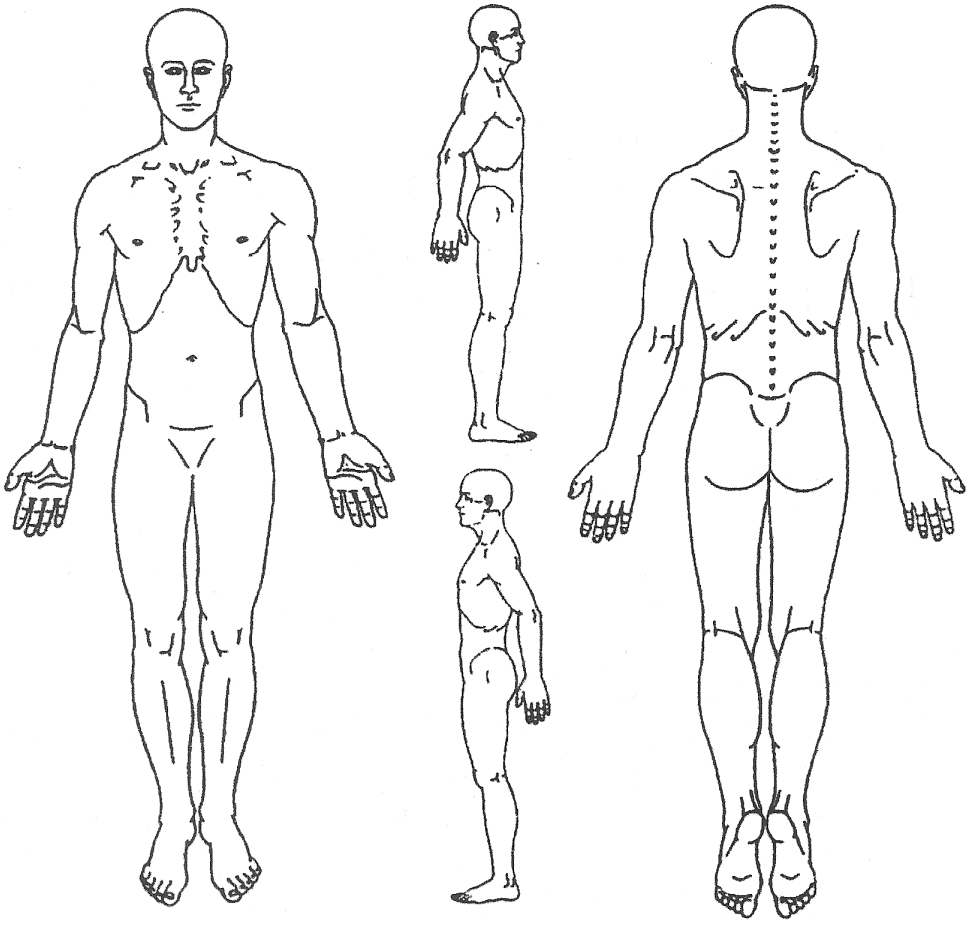
***Patients are asked to keep the clinic informed on any changes to the above information*.**

Previous massage/bodywork experience: __ No ___Occasionally ___Often – Type(s) _____

Please fill out this form completely and legibly. Leave nothing blank.
If something does not apply, write "N/A" on the line.

Mark the areas where you feel the described sensations on the pictures below.

Numbness	Pins & Needles	Burning	Aching	Stabbing
---------	00000	XXXXX	*****	//////



Neck - Shoulder - Arm Pain
On a scale of zero to ten,
I rate my discomfort as follows:

0 ⟷ 10
No pain Severe pain

Mid Back Pain
On a scale of zero to ten,
I rate my discomfort as follows:

0 ⟷ 10
No pain Severe pain

Low Back and Leg Pain
On a scale of zero to ten,
I rate my discomfort as follows:

0 ⟷ 10
No pain Severe pain

Please fill out this form completely and legibly. Leave nothing blank.
If something does not apply, write "N/A" on the line.

How Did You Hear About JJMassage?

Were you referred by (Check all that apply):

❏ Another patient, Name of Patient_____

❏ Website, Name of Site _____

❏ Other, _____

I understand that: Massage therapy (Which may include styles of: Swedish, Sports or Deep Tissue Massage) involves neither diagnosis nor treatment of any condition and is not a substitute for medical care. Draping will be used at all times. This is a full-body massage unless otherwise requested; neither breasts nor genitalia will be massaged. I may itemize here any areas on my body that I wish to be avoided, and these will be totally avoided (itemize here if relevant):

_____

If I am uncomfortable for any reason I may request to end the session and it will end promptly.

If client is under the age of 17, written consent from client's guardian or parent is required.

I affirm that I am able to receive Massage Therapy and that any of the information I have provided above does not prohibit me from doing so. I am aware that if I have a medical diagnosis that prohibits me from receiving Massage I must provide physicians written consent prior to services.

Client Signature:_____ Therapist Signature: _____