JF body work

CONTACT INFORMATION

Legal Name: _____ DOB: ___/___/___

Preferred Name: _____ Pronouns e.g. she/her or they/them _____

Mailing Address: _____

City, State, Zip: _____

Phone: _____ ☐ Yes my phone can receive text messages

Email: _____

Emergency Contact Name: _____ Phone: _____

Primary Care Provider Name: _____ Phone: _____

Were you referred to Jae by a friend? Y / N If so, who? _____

HEALTH STORY:

To start to understand who you are and how to create a helpful massage experience.

Occupation: _____

_____

Hobbies, activities, and movement: _____

_____

Have you ever received a professional massage? ◯ yes ◯ no

If yes: When was your last massage?_____ Frequency of receiving massage? _____

Pressure preferences: ◯ Light ◯ Medium ◯ Firm

Circle any past (p) and/or current (c):

Cardiovascular

P	C	Congestive heart failure	P	C	Embolism or blood clots
P	C	Low blood pressure	P	C	High Blood Pressure
P	C	Hemophilia	P	C	Pacemaker
P	C	Stroke	P	C	Other cardiovascular condition

Head and neck

P	C	Dizziness	P	C	Headaches or migraines
P	C	Hearing loss	P	C	Jaw pain (TMJ)

Musculoskeletal

P	C	Arthritis/joint pain	P	C	Joint replacement
P	C	Osteoporosis	P	C	Surgical pin or plate
P	C	Broken bones	P	C	Tendonitis

Neurological

P	C	Seizures	P	C	Numbness, tingling, lack of sensation
P	C	Sciatica	P	C	Multiple sclerosis
P	C	Epilepsy			

Skin

P	C	Skin conditions	P	C	Skin sensitivities

Other

P	C	Allergies: (list here)			
P	C	Asthma, shortness of breath	P	C	Emphysema
P	C	Cancer	P	C	HIV/AIDS
P	C	Digestive conditions	P	C	Other medical implant
P	C	Fibromyalgia	P	C	Compromised immunity
P	C	Insomnia or trouble sleeping	P	C	Depression
P	C	Anxiety	P	C	PTSD
P	C	Fatigue	Y	N	Currently pregnant?
					How many weeks:

Other conditions not listed, or more about the above conditions: _____

_____

Medications: _____

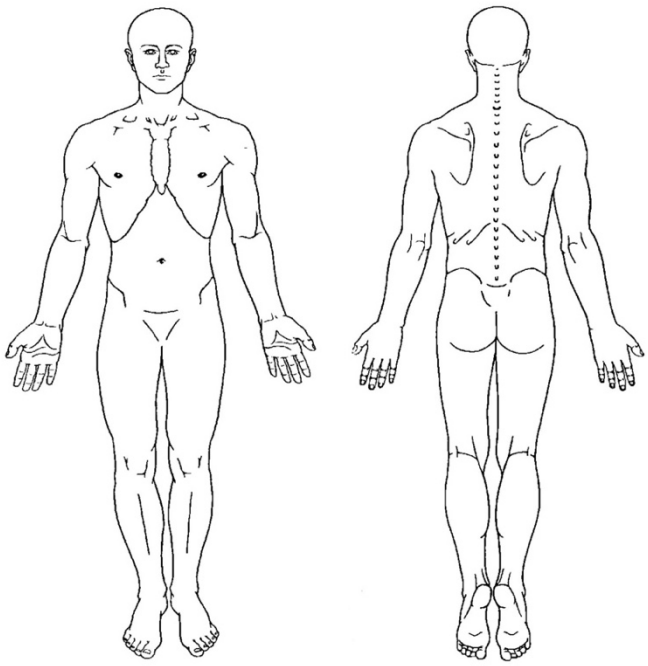
Other surgeries *(when & location):* _____

_____

Recent injuries and illnesses *(when & body location):* _____

_____

Circle any areas where you have pain, tension, or discomfort in your body, today or regularly:



Are there any areas you would like to focus on today?

_____

_____

Are there any areas you would like avoided today?

_____

_____

What are your goals for today's session? _____

_____

Is there anything else you want me to know to make this session more comfortable?

_____

Waiver *Please read and sign:* The above information is true to the best of my knowledge. I agree to inform the therapist of any changes in my health and medical conditions. I understand that this information will be kept confidential and that it is used only for clinical purposes and determining the appropriate massage therapy treatment plan.

I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation. I understand that today's services are not a substitute for medical care and that my therapist is not qualified to diagnose illness. I waive and release my therapist from any liability, past, present, and future, relating to massage therapy and bodywork.

Client Signature: _____ Date: _____