Client Information

1633 Fillmore Street, Suite 114
Denver, Co 80206
720-935-9980 • www.jlmtherapeutics.com

Name _____ DOB _____ Gender ❑ male ❑ female ❑ prefer not to say

Address _____ phone _____ email _____

Referred by ❑ friend _____ ❑ website ❑ social media ❑ Groupon/ClassPass ❑walk by

Emergency contact name _____ phone _____ relation _____

Occupation _____ Side dominance ❑ Right ❑ Left ❑ Both

What are your goals for today's session? _____

What are the top three places on your body you want to address in our time together? _____

Have you had massage or yoga therapy in the past? If so, how recently and how often? _____

What sort of massage pressure do you prefer? _____

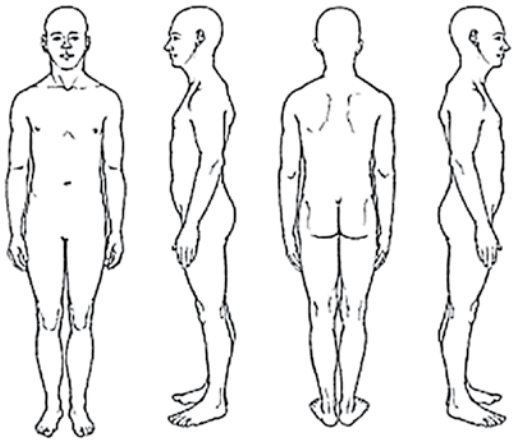
What sort of yoga do you practice? _____

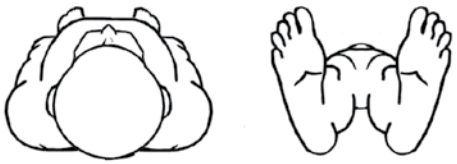
How do you sleep in general? _____

How are you feeling today? _____

Health Conditions

Please check the category and mark any conditions plus list treatments for those conditions. Use the body diagram to mark areas of past physical ailments, injuries and surgeries as well as any muscle and/or joint pain, stiffness, numbness, tingling, swelling, bone breaks, sprains, strains, skin bruising, sensitivity, rashes, or infections.





❑ **Musculoskeletal** *(Please note these on the body diagram)*

___ arthritis ___ osteopenia ___ osteoporosis ___ scoliosis
___ broken bones ___ dislocations ___ surgeries ___ injections
___ acne ___ skin rashes ___ boils ___ abscesses
___ herniation ___ implants ___ infections ___ cancer

❑ **Reproductive**

___ pregnancy ___ period ___ endometriosis ___ prostate enlargement
___ testicular pain ___ penis pain ___ painful intercourse ___ pelvic floor dysfunction
___ infections ___ cancer

❑ **Digestive**

___ Crohn's _____ IBS ___ diabetes ___ gas
___ bloating ___ constipation ___ diarrhea ___ intestinal polyps
___ kidney disease ___ infections ___ incontinence ___ cancer

❑ **Circulatory**

___ heart disease ___ arrhythmia ___ arteriosclerosis ___ pacemaker
___ stint ___ shunt ___ stroke ___ varicose veins
___ blood clots ___ infections ___ cancer ___ high/low blood pressure

❑ **Respiratory**

___ asthma ___ COPD ___ smoking ___ infections ___ cancer

❑ **Neurological**

___ Sciatica ___ MS ___ Parkinson's ___ Fibromyalgia ___ epilepsy ___ seizures ___ headaches
___ migraines ___ dizziness ___ memory loss ___ confusion ___ overwhelm ___ infections ___ cancer

❑ **Ocular**

___ Lasik ___ glaucoma ___ retinal detachment ___ nearsightedness ___ farsightedness ___ infections ___ cancer

❑ **Endocrine**

___ edema ___ allergies ___ thyroid ___ testosterone ___ estrogen ___ adrenaline ___ infections
___ cancer ___ swollen lymph nodes

❑ **Psychosocial**

___ anxiety ___ depression ___ loneliness ___ constantly active ___ agoraphobia ___ alcohol ___ drug use

Is there any condition not listed above or information you think I should know in regard to your health, your progress or your care?

_____

Office Policies

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Cancellation – a 48-hour notice is required for cancellation of an appointment (online, text or voicemail) or you will be charged in full for the appointment. Full payment is due at time of scheduled service and will be required before another appointment is scheduled.

Tardiness – Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time to your appointment.

Sickness – massage/yoga therapy is not appropriate care for infectious or contagious illnesses. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If you cancel within the 48 hour notice period, the cancellation fee may be waived.

Consent for Treatment

I understand that the massage/yoga therapy I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or yoga therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/yoga therapy practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/ yoga therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

You have my consent to contact my health care provider(s) should the need arise (chiropractor, physical therapist, psychotherapist, acupuncturist, naturopath, MD, DO, surgeon, etc).

_____ Initials _____ date

Client signature _____ date_____

Practitioner signature _____ date_____

Consent to treatment of a minor: By my signature below, I hereby authorize _____ to administer massage/ yoga therapy to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ date_____