Motivity with Joi

Orthopedic Massage & Functional Movement

Personal Information

Name_____ Phone _____

Address _____ City/State/Zip_____DOB _____

Occupation_____Email_____

Emergency Contact_____Relationship_____Phone _____

How did you hear about Joi? _____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ yes ☐ no

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse?_____

_____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list:_____

_____

Please indicate any of the following that apply to you.

☐ Cancer
☐ Headaches/Migraines
☐ Arthritis
☐ Diabetes
☐ Joint Replacement(s)
☐ High/Low Blood Pressure
☐ Neuropathy
☐ Fibromyalgia
☐ Stroke
☐ Heart Attack
☐ Kidney Dysfunction
☐ Blood Clots
☐ Numbness
☐ Sprains or Strains

Explain any conditions you have marked above:

_____

_____

_____

_____

Massage & Movement Information

Have you had a therapeutic massage before? ☐ yes ☐ no

Do you exercise? ☐ yes ☐ no . If yes, what and how often?_____

_____

What type of therapeutic session are you seeking?

__Movement __Massage __Combination

What massage pressure do you prefer?__Light __Medium __Firm

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain_____

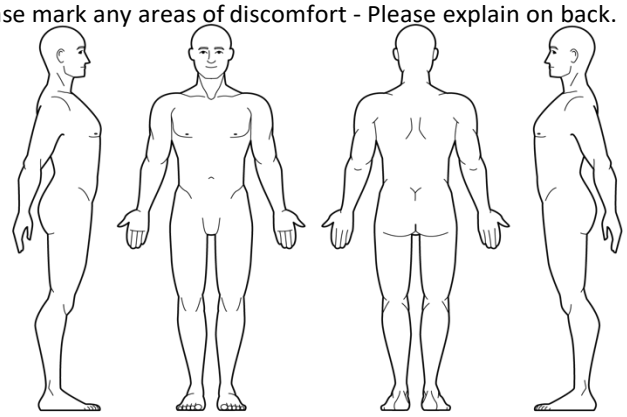
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain_____

What are your goals for this treatment session?

_____

Please mark any areas of discomfort - Please explain on back.



I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Therapist Signature _____ *Date* _____