Name: _____ D.O.B: _____

Address: _____

E-mail: _____

Phone Home: _____

Mobile: _____

Occupation: _____

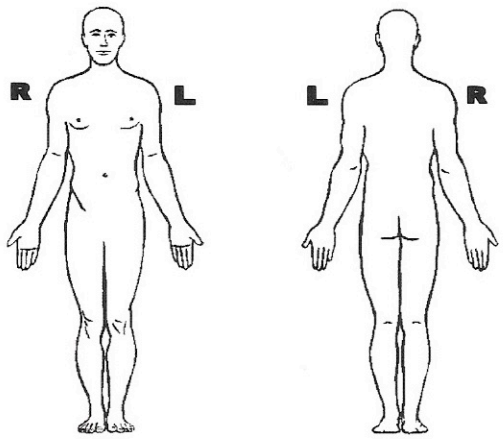
Recreational Activities: _____

Emergency contact: _____

How did you first hear about us? _____

Have you seen a remedial therapist before? Yes ☐ No ☐

IDENTIFY SPECIFIC AREAS OF SORENESS:



Are you in a Health Fund? Yes ☐ No ☐

Which fund? _____

Please tick (✓) all conditions that apply now. Put a **P** for past conditions:

__ Heart, circulatory problems
__ High/low blood pressure
__ Varicose veins
__ Blood clots
__ Phlebitis
__ Infectious disease
__ Rash, athlete's foot/tinea
__ Allergies
__ Diabetes
__ Pregnancy
__ Cancer/tumours
__ Asthma or lung conditions
__ Hernias
__ Abdominal or digestive problems
__ Arthritis
__ Numbness or tingling
__ Muscle or bone injuries
__ Muscle or joint pain
__ Chronic pain
__ Headaches or migraines
__ Vision problems or contact lenses
__ Hearing problems
__ Fatigue
__ Depression
__ Seizures
__ Stroke
__ Skin disorders
__ Previous motor vehicle accident/trauma

Other medical conditions not listed: _____

Current medications (including aspirin, ibuprofen, herbs, vitamins etc): _____

_____

Recent surgeries: _____

Signature: ..... Date: .....

JMC Remedial Massage

Surname:

First Name: