JOs Body Shop NY

906 South Street / Peekskill / NY 10566 914.960.1367

Name: _____ Address _____

Date: _____ Phone: _____ Cell: _____ Emergency Contact: _____

Email: _____ (Contact Number): _____

Occupation: _____ Exercise Type/Schedule? _____

D.O.B _____

Primary Concern: _____

It hurts when I? _____

When did it start? _____ How Frequent? _____

Prior/Current Diagnosis/Treatment? _____

Are you seeing a health care provider? Please describe: _____

Level of Pain (1-mild 10-severe) _____ Stress (1-10) _____ Energy (1-10) _____

Have you ever had massage? Y or N What type(s) of massage? _____ Last treatment? _____

Your desired outcome of our work together, today? _____

Senstive to Touch? (ticklish)? _____

Are you Pregnant? Y or N Months? _____ Menopause symptoms/how long? _____

Are you allergic or sensitive to anything (essential oils, nut oils, scents)? _____

Current medications? (please list medication and purpose) _____

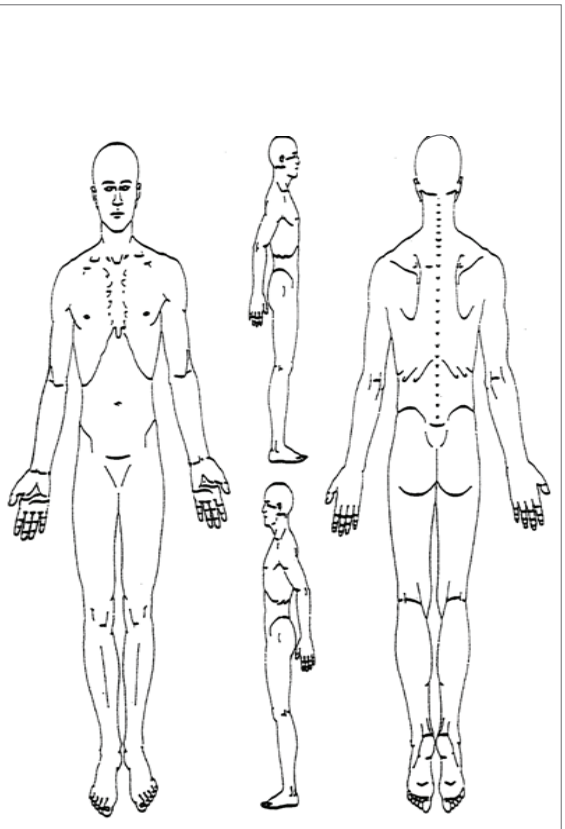
Vitamin Intake? _____ Exercise Regime? _____

List any prior surgeries: _____

Accidents/Injuries/Treatments/Dates: _____

Medical History: Please circle or list.

- ☐ Skin Conditions - Psoriasis, Rash, Warts, Hives, Skin Cancer, Sensitive, Dry, other/where: _____
- ☐ Lymphatic Conditions - Swollen Glands, Fingers, Feet, Ankle(s), Nasal other/where: _____
- ☐ Joint Problems - Rheumatoid Arthritus, Osteoarthritis, Strains/Sprains, ACL/PCL, Meniscus, Trigger Finger, Tendonitis, Bursitis, other/where: _____
- ☐ Bone Conditions - Osteoarthritis, Osteoporosis/Penia, Fracture, Disc Issues, Herniations, Scoliosis, other: _____
- ☐ Headaches - Frequency? _____ TMJ, Sinusitis _____ Where? _____ Vision Problems? _____
- ☐ Circulatory Conditions - CHF, High/Low Blood Pressure, Varicose Veins, Blood Clots, Cholesterol, other: _____
- ☐ Neurological: Numbness, Tingling, Pins & Needles, Sciatic, TOS, Carpal Tunnel, other/where: _____ Describe sensation? _____
- ☐ Diabetes? Y or N ☐ Hearing Conditions: Aids/Tinnitus _____
- ☐ Muscle Conditions: Strains, Tight/Weak: _____
- ☐ Digestive Conditions - Constipation/IBS: _____
- ☐ Lung Conditions - Asthma, COPD, Allergies: _____
- ☐ Infectious Diseases: Athletes foot, AIDS, other: _____
- ☐ Cancer / Tumors: _____
- ☐ Sleep Disorders/Depression: _____
- ☐ Other: _____



Please mark any areas of tension/pain/discomfort.

Disclaimer/Cancellation Procedure:

- ☐ I understand and agree that should I cancel an apointment less than 24 hours before the scheduled time or if I do not show for the scheuled appointment, I am subject to a fee equal to the cost of the missed appointment.
- ☐ I affirm to have notifified the massage practicioner of any medical issues to date. **(review below)***
- ☐ I understand that massage therapy is a soft tissue treatment and is not chiropratic treatment, and that the services rendered today are no substitute for medical care of any kind, if and when needed.
- ☐ I understand that massage is entirely therapeutic and not sexual in nature.
- ☐ The Information you provided and the treatment shared is confidential and follows HIPAA (The Health Insurance Portability and Accountability Act of 1996) regulations. If, the therapist feels it is necessary to contact your medical practicioner, the therapist will only be able to do so with a written release from you. The therapist will only release records of your treatment history by written request from you or a court subpoenea.
- ☐ By signing this release, I hereby waive and release my therapist from any and all liability, past, present, or in the future relating to massage therapy and bodywork. I also understand that I may feel discomfort after the massage for a few days due to a release of tension or toxins in the body tissue. Additionally, I do not hold my therapist responsible for any continued or chronic ailment(s).

COVID-19 Intake & Procedure(s):

- Are you Vaccinated Yes _ No_ (if yes, please offer proof of vacination(s)/booster(s), Dates and Brand)

- Have you been afflicted with COVID-19 or tested positive for the virus or the antibodies? Yes _ No_ (if yes, please explain)
- Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes _ No_ (if yes, please explain)

* Do you practice social distancing? Yes _ No_ (if yes, please explain)

- Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has Coronavirus-type symtoms? Yes _ No_ (if yes, please explain)
- Do you practice social distancing? Yes _ No_ (if yes, please explain)

It is required that you wear a face mask before entering the shop; your temperature will be taken; you will be asked to wash your hands. Touchless payment (if you prefer) can be accepted via Venmo or Zelle using my email address: julie@josbodyshopny.com.

Your Therapist and Therapeutic Environment:

Your therapist will be taking every precaution to guarantee client/therapist safety. The environment is constantly cleaned and an air purifier and UV light is used to sterilize - before and after each session.

General Information:

- Try not to eat a large meal for atleast 2 hours prior to treatment.
- Please remove all jewelery, eye glasses, contact lenses. Secure long hair.
- Void your bladder.
- Undress to your level of comfort with or without underwear is completely up to you.
- Notify the therapist if you are uncomfortable in any way, temperature, pressure, pain.
- Feel free to ask questions before, during or after your therapeutic session.
- Relax and enjoy. You are in good hands.

Client Name (please print): _____

Client Signature: _____ Date: _____

(Guardian's Release for under 18 years old patients)