Jo Keogh, CMT, LMT, TTT
1700 Little Meadow Road
Guilford, CT 06437
(475) 331-0251 • JoKeoghLLC@gmail.com

Name: _____ Date: _____

Phone: _____ (C/W/H) Email:_____

Would you like to receive emails regarding promotions and upcoming events at Jo's practice? _____

Address: _____

Date of Birth: _____ Occupation: _____

Have you had massage work done before? _____

If so, was there anything you particularly liked or disliked about past massage treatments? _____

_____

How did you hear about Jo's practice? _____

Please describe the reason for your visit today: _____

_____

Are you taking any medications? If so, which? _____

Are you pregnant? _____Yes _____No Due Date: _____

Have you consumed any alcohol within the past 24 hours? _____Yes _____No

Please indicate a history of any of the following medical conditions:

___abdominal pain
___accident
___acute injury
___allergies to oils, perfumes
___anxiety
___arthritis, bursitis, gout
___back pain (low)
___back pain (mid)
___back pain (upper)
___blood clots
___breast augmentation
___broken bones
___cancer
___carpal tunnel syndrome
___chronic fatigue syndrome
___chronic tension
___colitis
___contact lenses
___decreased range of motion
___depression
___diabetes
___dizziness
___epilepsy
___fever
___fibromyalgia
___headaches
___heart attack
___heart disease
___hemophilia
___high blood pressure
___HIV
___irritable bowel syndrome
___joint ache
___mastectomy
___multiple sclerosis
___neck pain
___nervous tension
___numbness
___osteoporosis
___phlebitis, thrombosis
___rashes, skin disorders
___sciatica
___scoliosis
___seizures
___shoulder pain
___sprains
___stroke
___surgery
___tumors, cysts
___varicose veins
___whiplash

Are there any other conditions of which I should be aware? _____

_____

Have you ever been diagnosed with PTSD or CPTSD? _____

Do you have a trauma history (abuse, assault, major illness, loss, etc.)? _____

_____

Please list any therapy/medical care that you are receiving, along with the name of your health care

practitioner(s): _____

_____

Do you follow a regular exercise program? _____Yes _____No

Are you currently under any undue stress? ____Yes ____No Please explain _____

_____

Is there anything else I need to be informed of? _____

_____

I understand that massage and/or energy work are not meant to replace medical examinations, diagnosis, or treatment. If symptoms are severe or persistent, I should consult my health care practitioner immediately.

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist prescribes neither medical treatment nor pharmaceuticals, nor performs any spinal manipulations.

I understand that the massage therapist must be aware of existing medical conditions. I have stated all my known medical conditions, and take it upon myself to keep the massage therapist updated on any changes to my physical health.

I understand that I have the right to terminate a massage therapy session at any time should I feel that the treatment I am receiving is inappropriate and/or not fulfilling the treatment goals set by myself and the massage therapist.

I understand that any inappropriate behavior on my part will lead to the immediate termination of my treatment by the massage therapist, and that payment for the full session will be required.

I understand that when I make an appointment, that time is reserved exclusively for me. I will remit payment for any appointments not cancelled at least 24 hours in advance (barring illness or emergency).

I have read and understand the above conditions and policies.

_____

(Signed)

_____

(Dated)