

Mojo Physio 480-922-4499

Confidential Client Information. Please fill out, save, print & bring with you.

You can also fill out, save & email to gina@mojophysio.com.

Today's Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Contact Phone # _____ Date of Birth _____

E-Mail _____

Emergency Contact _____ Phone # _____

How did you find out about us? _____

Women:

Are you currently pregnant?

Breast feeding?

Men and Women

What is your primary reason for today's visit?

If you are currently seeing any other health care professionals for the treatment of your condition, what specialty, or type of clinic/doctor are you seeing?

Where, specifically, are you experiencing pain or discomfort? If you are having symptoms in more than one area please list the worst area first.

Please check one or more of the following types of pain if they apply to your condition:

sharp stabbing pain

deep dull ache

burning

light soreness

tingling

numbness

Is the pain you are experiencing constant or intermittent? _____

Would you call your pain? mild moderate severe

Can you approximate when your pain began?

Can you recall what event or circumstance initiated your pain?

What conditions or activities exacerbate your pain (i.e. bending, standing, etc.)?

When you are stressed, where do you feel the most tension in your body?

What, if anything do you do that makes your pain feel better?

If you are experiencing low back pain, does it feel better to bend at your knees while laying flat on your back?

Do you take prescription drugs?

If so, what do you take & for what reason?

Do you suffer from jaw pain, TMJ, or clenching that you are aware of?

Have you had any foot or ankle pain in the past 2 years?

If yes, please explain:

Do you experience frequent headaches?

If yes, are they located: frontal (behind eyes) temples base of neck

back of head or in another area

Have you broken any bones in the last two years? NO

If any, where? _____

Have you ever had surgery? If so, describe below:

Are you sensitive to touch or pressure in any areas?
If yes, what areas?

Do you have any other medical conditions that we should be aware of?

Please take a moment to carefully read the following information and sign where indicated. Your signature acknowledges:

If you have a specific medical condition or specific symptoms, bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided. I understand that the bodywork I receive is provided for the relief of muscular tension. I further understand that bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician or their qualified medical specialist for any mental or physical ailment that I am aware of. I understand that bodywork therapists 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 bodywork 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 Mojo Physio updated as to any changes in my medical profile and understand that there shall be no liability on the therapists/Mojo Physio's part should I neglect to do so.

→ CANCELLATION POLICY: 24 HOUR NOTICE IS REQUIRED FOR ALL CANCELLATIONS. FULL TREATMENT FEE WILL BE CHARGED FOR ALL NO SHOWS AND LAST MINUTE CANCELLATIONS.

I have read and agree to the MOJO PHYSIO Cancellation Policy.

→ Date: _____

→ Client Signature Parent/Guardian if under 18 yrs. of age. By typing your name below, you are agreeing to the terms and conditions.
