DATE:_____
(mm/dd/yyyy)

Susan C. Jackson & Associates
Massage Therapy Clinic

Policies and Principles:

1. All Clinic patients MUST COMPLETE A CASE HISTORY FORM. INITIAL VISIT WILL INCLUDE BLOOD PRESSURE READING, CASE HISTORY REVIEW AND A POSSIBLE ASSESSMENT (depending on individual cases).
2. LATE ARRIVALS lose the privilege of a full hour treatment.
3. Missed appointments must be notified within 24 HOURS advance or payment is required.
4. If for any reason the clients insurance company does not approve payment they will assume the outstanding balance and understand that they are completely responsible for payment of treatment(s).

NAME:_____ ( )M ( )F E-MAIL ADDRESS:_____

ADDRESS:_____

_____ POSTAL CODE_____

PHONE: (H)_____ (W)_____ OCCUPATION:_____

D.O.B. _____/_____/_____ INSURANCE COMPANY:_____ POLICY#_____ ID#_____
(mm./dd/yyyy)

Family Physician:_____

Main Complaint:_____ Other Complaints:_____

Type of Pain:_____ Does it radiate (travel)?:_____

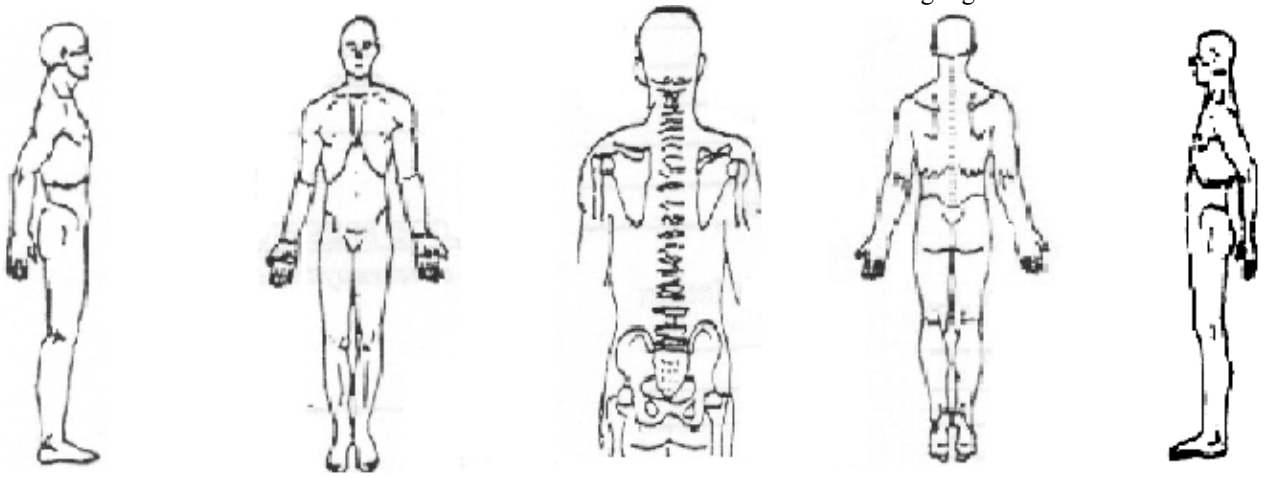
If so, where?_____

What tends to relieve the pain?_____

What aggravates the pain?_____

Please Indicate on the pictures below:

"**X**" where you have Joint & Muscle Stiffness
"**O**" where you have pain
"**N**" where there is numbness & tingling



How Did You Become Aware Of Our Clinic:_____ **Referring Doctor:**_____