



Jin Shin Do Registration Form

Personal Information	Today's date: _____
Name: _____	Date of Birth: _____
Address: _____	Age: _____
City: _____	SSN: _____
State: _____	Zip: _____
Best Phone: _____	Alternate Phone: _____
Employer: _____	Occupation: _____
Work Phone: _____	Emergency Contact Person: _____
Relationship: _____	Phone # _____
Address: _____	Who is your primary care doctor? _____
Referred to this office by: _____	Learned about Holistique Medical Center from: _____
Have you recently been in a car accident? _____	When? _____
Have you had any serious injury in the past? _____	When? _____
Have you seen a Professional Massage Therapist in the past? _____	

Insurance Information
Person responsible for account: _____
Relationship: _____
Insured's DOB: _____
Primary Insurance: _____
Group #: _____
Subscriber #: _____
Secondary Insurance: _____
Group #: _____
Subscriber #: _____

Health Problems – Please list your main health problems, duration, and current treatments
1. _____
2. _____
3. _____
4. _____

Massage- Please list anatomical area you would prefer massage treatment. Eg lower back, neck, arms.
1 _____
2 _____
3 _____
4 _____