Client Information _____ OFFICE USE ONLY

Today's Date:_____ Name:_____ DOB:_____ Age:_____

Phone:_____/_____ Email:_____
Work/Cell Home

Address:_____ City/State/Zip:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Occupation:_____ Referred by:_____

Health Information

Medications:_____

Allergies/Sensitivities:_____

Any Current Medical Interventions/Supervisions:_____

_____

Please **check** any conditions in your medical history and **circle** any that have occurred in the last year.

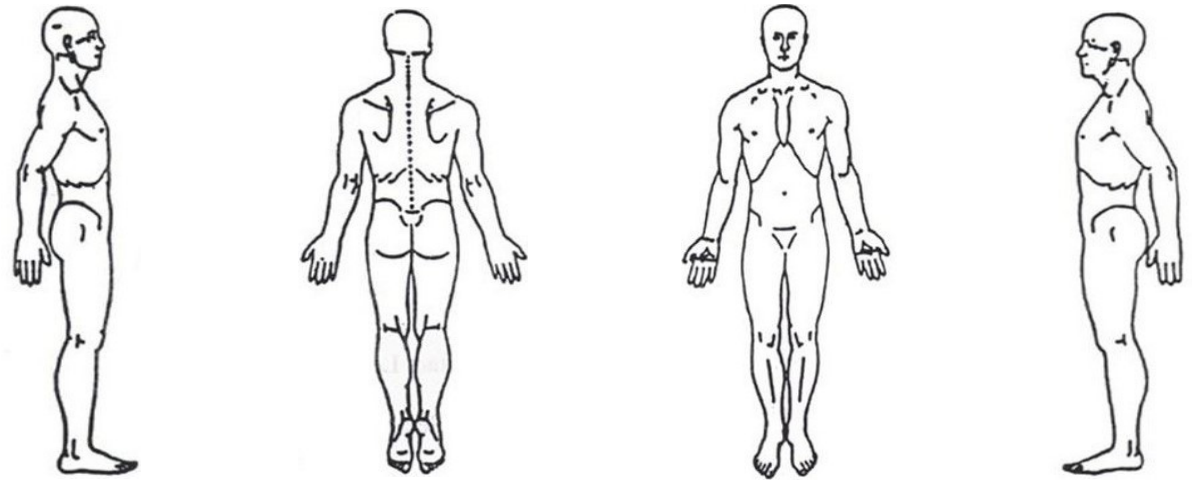
- ○ Anxiety
- ○ Arm Pain
- ○ Arrhythmia
- ○ Arthritis
- ○ Asthma
- ○ Athlete's Foot
- ○ Autoimmune Disorder
- ○ Back Pain
- ○ Blood Clots
- ○ Bruise Easily
- ○ Bunions
- ○ Bursitis
- ○ Cancer
- ○ Car Accident
- ○ Chronic Fatigue
- ○ Contagious Skin Conditions
- ○ Cuts/Bruises
- ○ Decreased Sensation
- ○ Depression
- ○ Diabetes
- ○ Digestive Issues
- ○ Dislocation
- ○ Fainting
- ○ Fibromyalgia
- ○ Fracture
- ○ Headache
- ○ Head Injury
- ○ Heart Condition
- ○ Hyper/Hypotension
- ○ Infectious Blood Disease
- ○ Inflammation
- ○ Kidney Disease
- ○ Lymph Edema
- ○ Multiple Sclerosis
- ○ Neck Pain
- ○ Neurological Condition
- ○ Neuropathy
- ○ Numbness
- ○ Osteoperosis
- ○ Phlebitis
- ○ Pregnancy
- ○ Recovering From Surgery
- ○ Restlessness
- ○ Sciatica
- ○ Seizures
- ○ Shingles
- ○ Skin Rash
- ○ Sleep Issues
- ○ Spine/Disk Injury
- ○ Sprain/Strain
- ○ Stroke
- ○ Tendonitis
- ○ Tingling
- ○ TMJ/Jaw Issues
- ○ Torn Cartilage
- ○ Ulcers
- ○ Varicose Veins
- ○ Vertigo/Dizziness
- ○ Warts
- ○ Whiplash

Accidents/Surgeries:_____

Other Conditions:_____

Areas of Broken Skin (rash, wounds, etc.):_____

Mark/Shade Areas of Tension, Discomfort, or Pain:



Massage Information

Have you had a professional massage before?_____How Recently?_____

Reason for seeking treatment today: ○ Relaxation ○ Specific Problem (Please Describe):

_____

How much pressure do you prefer? ○ Light ○ Medium ○ Firm ○ Deep

Knowing that NO work is performed in the genital/breast regions, are there any areas you'd like me to avoid?_____

Do you have difficulty lying on front, back, or sides? If so, which?_____

How does your body temperature usually feel; too hot, too cold, or just right?_____

What exercises do you participate in?_____

Do you perform repetitive movements for work or recreation? ○ Yes ○ No

What are they?_____

Do you sit for long periods?_____How would you rate your average stress level(1-10)?_____

How do you experience stress in the body? _____

How do you usually feel (cheerful, anxious, etc.)?_____

Do you have any contagious conditions that may put the massage therapist or other clients at risk?

○ Yes ○ No

Do you have any injuries or conditions that prevent you from receiving massage therapy?

○ Yes ○ No

Any comments, questions, or concerns?_____

I certify that the included information is true to the best of my knowledge.

I understand the following:

- **Services offered are intended for general wellness, stress reduction, and relief of muscular tension.**
- **I should see a physician/health care provider for diagnosis & treatment of suspected medical issues.**
- **Massage therapists do not diagnose and nothing said during treatment should be construed as such.**
- **Risks associated with massage therapy include, but are not limited to:**
  - **Superficial bruising**
  - **Short-term muscle soreness**
  - **Exacerbation of undiscovered injury**
- **If I experience pain, I will inform my therapist so that the techniques can be adjusted to my comfort.**
- **It is my responsibility to inform the therapist of any changes in my health.**
- **Oregon law mandates that all clients be draped during the entirety of the massage.**
- **This is a non-smoking, odor-neutral massage office.**
- **Any client who arrives under the influence of drugs or alcohol will be asked to leave.**
- **Harassment of any kind will not be tolerated and the session will be terminated if this occurs.**
- **The therapist or client may stop the massage at any time.**

In addition, the following should be acknowledged and taken into account:

- **I agree to a 24-hour cancellation notice: otherwise, I will be expected to pay for the session.**
- **I understand that if I am late for an appointment, it will not be extended past my appointment time.**
- **If a session is shortened due to my lateness, I am responsible for the entire appointment fee.**

Client Signature:_____Date:_____