MASSAGE THERAPY INTAKE FORM

14355 SW Allen Blvd. STE 150, BEAVERTON, OR 97005 (503)806-5700

Name: _____ Date of Birth: _____

Address: _____ State: _____ Zip Code: _____

Phone: _____ E-Mail: _____

Referred By: _____

GENERAL & MEDICAL INFORMATION

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session Yes/No How Recent? _____ If you answer "Yes" to any of the following questions, please explain as clearly as possible.

Yes No Do you frequently suffer from stress:

Yes No Do you have Diabetes?

Yes No Do you have frequent headaches?

Yes No Are you pregnant?

Yes No Do you suffer from Arthritis?

Yes No Are you wearing contact lenses?

Yes No Do you have high blood pressure?

Yes No If yes are you taking medication?

Yes No Have you had any broken bones within the past 2 years? Yes No

Yes No Have you been in an accident or suffered any injuries in the past 2 years?

Yes No Do you have tension or soreness in specific areas? Please specify:

_____

_____

_____

Yes No Do you have any heart or circulatory Problems?

No Do you suffer from Epilepsy or Seizures?

Yes No Do you suffer from joint swelling?

Yes No Do you suffer from Vericose Veins?

Yes No Do you have any contagious diseases?

Yes No Do you have Osteoporosis

Yes No Do you have any allergies?

Yes No Do you bruise easily?

Yes No Do you suffer from back/neck pain? Yes

Yes No Do you have numbness or stabbing pains Anywhere?

Yes No Are you sensitive to touch or pressure in any area? (Explain Below)

Yes No Have you ever had surgery?

Yes No Do you have any other medical condition Or are you taking any medications that We should know about?

Comments:

_____

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