**1920 NW Lovejoy Street**
**Portland, OR 97209**
**503-417-1774**

# MASSAGE INTAKE

Name: ______________________________ Date: ____________

Address: ______________________________________________

City: ________________________ State: ______ Zip: ____________

Home Phone: ____________________ Work Phone: ____________________

Mobile Phone: __________________ E-Mail: ________________________

Date of Birth: __________________ Occupation: ____________________

Referred by: ___________________________________________

In Emergency Notify: ____________________ Phone: ______________

Relationship to you: ____________________________________

Please check any of the following that apply to you:

- ☐ Skin Disorders
- ☐ Heart Conditions/Heart Disease
- ☐ Diabetes
- ☐ Nausea
- ☐ Stroke
- ☐ Psychological
- ☐ Pregnant
- ☐ Epilepsy
- ☐ Frequent Headaches
- ☐ Easy Bruising
- ☐ Gastrointestinal
- ☐ Musculoskeletal
- ☐ Communicable Disease
- ☐ Seizures
- ☐ Varicose Veins
- ☐ Arthritis
- ☐ Surgery
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Allergies
- ☐ Cancer (current or past)
- ☐ Injuries/Accidents
- ☐ Compromised Immune
- ☐ Respiratory Disorder

Please explain any of the health problems indicated above:

______________________________________________

______________________________________________

Please list any medications or supplements (including herbs and supplements) you are currently taking:

______________________________________________

______________________________________________

*Please continue…*

Are you currently under the care of a physician? ☐Yes ☐No   If so, please explain and include physician name and phone number:

Have you ever received massage or bodywork before? ☐Yes ☐No   If yes, how was it?

What would you like to receive from this massage?

Would you like me to focus on any specific area(s)?

Would you like me to avoid any specific area(s)?

## Client Consent:

I attest that the above is true and accurate to the best of my knowledge. I understand I will be receiving a therapeutic massage for the purpose of maintaining good health and physical condition. Further, I understand that massage therapists may not diagnose or treat injuries/diseases and that massage should not take the place of a doctor's care when necessary. I also acknowledge the 24 hour cancellation policy: without 24 hours notice of cancellation, I will pay for the missed appointment.

Signature

Date Signed