Michelle E. Read, LMT #7618
4838 NE Sandy, Suite #210 • Portland, OR 97213
(503) 442-3963 • michelle@goodmedmassage.com

Confidential Information

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Referred by: _____

Reason for Visit

Primary reason for visit: _____

When did you first notice it?_____ What brought it on? _____

Describe any stressors occurring at this time: _____

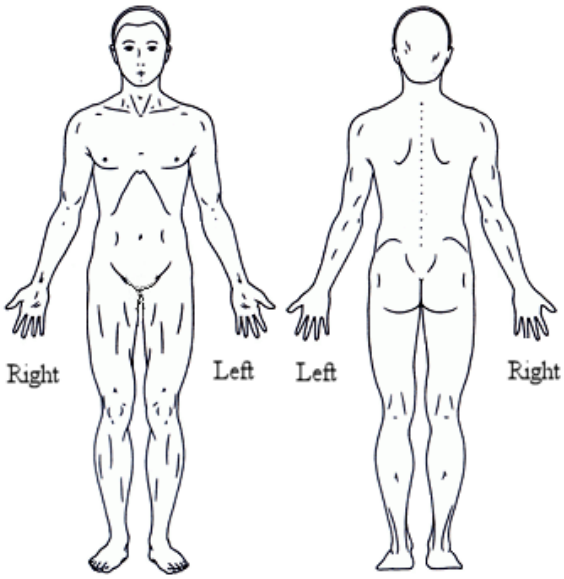
What activities provide relief? _____ What makes it worse? _____

Is the condition getting worse? _____ Does it interfere with work ____ sleep ____ recreation ____

Is this visit related to a work-related injury or auto accident? work ____ auto ____ neither ____

Please list in order of importance, any other reasons you are here today _____

_____



Circle degree of discomfort: 0 none, 10 severe

0 1 2 3 4 5 6 7 8 9 10

Mark your sensations on the picture:

Numbness = = = Sharp/Stabbing ///

Dull Ache OOO Pins, needles +++

Burning XXX Other _____ ^ ^ ^

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Medical History

Are you under the care of another health care provider(s)? _____ Reason(s) _____

Name(s) of Practitioner _____

Have you had massage before? _____ What type(s)? _____

Current medication/supplements _____

Any noticeable side effects? _____

Allergies/Sensitivities _____

Any illness, injury, surgery or trauma in past 3 years or that still affects you (date, treatment, status):

_____

_____

Mark any conditions you have currently or have experienced recently (past year):

General
___ Dizziness
___ Fainting
___ Headaches/Migraines
___ Sleep Disorder
___ Fatigue

Muscles & Joints
___ Muscle Cramps
___ Swollen Joints
___ Painful Joints
___ Stiff Joints
___ Joint Replacement
___ Joint Instability
___ Sore Muscles
___ Weak Muscles
___ Sprains/Strains
___ Broken Bones
___ TMJ Issues
___ Disc Problems
___ Scholiosis
___ Arthritis
___ Osteoporosis

Genito-Urinary
___ Kidney Infection
___ Kidney Failure
___ UTI
___ Bladder Control Loss
___ Painful Periods
___ Currently Pregnant
___ IUD

Nervous System
___ Numbness/Tingling
___ Shooting Pain
___ Sciatica
___ Depression
___ Anxiety
___ Confusion
___ Loss of Memory

Respiratory
___ Asthma
___ Bronchitis
___ Common Cold
___ Flu

Cardio-Vascular
___ High Blood Pressure
___ Low Blood Pressure
___ Heart Condition
___ Chest Pain
___ Poor Circulation
___ Strokes
___ Anemia
___ Edema
___ Varicose Veins
___ Blood Clots
___ Phlebitis
___ Aneurysm

Gastro-Intestinal
___ IBS
___ GERD
___ Hepatitis
___ Constipation
___ Diarrhea
___ Nausea
___ Abdominal Pain
___ Ulcer

Skin or Allergies
___ Boils
___ Scar Tissue
___ Acne
___ Bruising Easily
___ Eczema/Dermatitis
___ Rash
___ Psoriasis
___ Warts
___ Fungus
___ Itching
___ Sensitive Skin
___ Cut/Bruise/Burn
___ Herpes
___ Other Contagious Condition

Other
___ Cancer
___ Tumors
___ Epilepsy
___ Diabetes
___ Chronic Pain

I verify that all of the information provided is correct and current to the best of my knowledge and will inform my practitioner of any changes in my health.

Signature: _____ **Date:** _____

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Massage Policies

Please read the following statement carefully, then sign and date at the bottom

- I take responsibility to update any pertinent health or contact information during future visits. I take responsibility for my personal belongings.
- I understand that the therapist does not diagnose, treat, or prescribe for any illness, ailment or disease, nor do spinal adjustments. Massage is not a substitute for medical examinations and/or diagnosis, and I should see a physician if needed.
- I am aware that this is a non-sexual massage. Any misconduct or inappropriate behavior will result in immediate termination of the massage with full payment due. I understand that I will be fully covered with a sheet (known as a "drape") at all times and only the body part being worked on will be uncovered.
- I understand that I am in control of my session and can stop at any time; I will comment on my comfort or discomfort regarding pressure, technique, or area. I understand that for my own safety and my therapist's, it is unacceptable to receive bodywork under the influence of alcohol or illicit drugs.
- If running late for an appointment, I agree to call as soon as possible; I understand that my time may be shortened as a result. I understand that 24 hours notice of cancellation is required. For a late cancellation or missed appointment, I will be responsible for a $30 fee.
- It is my responsibility to pay for all services provided. In the event that my insurance company denies payment or makes a partial payment, I am responsible for the balance. By paying for my session at the time of service, I qualify for a time of service discount.
- I acknowledge that I received this office's Notice of Privacy Practices, which describes my privacy rights and how my health information may be used or disclosed.
- The areas I feel **comfortable** receiving massage include:

Scalp	Abdomen	Thighs	Neck
Face	Arms	Lower Legs	Back
Upper Chest	Hands	Feet	Hip/Glut Area

Client Signature: _____ **Date:** _____