

ALDERWOOD MASSAGE THERAPY  
347 NE FORD ST / PO BOX 426  
McMINNVILLE OR 97128 (503) 434-1738  
CONFIDENTIAL CLIENT HEALTH INFORMATION

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NAME: \_\_\_\_\_ GENDER: (M) \_\_\_ (F) \_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ WORK: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

MARITAL STATUS: SINGLE \_\_\_ MARRIED \_\_\_ E-MAIL: \_\_\_\_\_

NAME OF SPOUSE / SIGNIFICANT OTHER: \_\_\_\_\_

AGES OF CHILDREN LIVING AT HOME: \_\_\_\_\_

REFERRED BY (Please write the name of a Friend, Specific Ad or Coupon): \_\_\_\_\_

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1. Are you currently under the care of a Primary Health Care Provider? \_\_\_\_\_

If yes, please explain your health concerns: \_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_

(needed if you have a condition that could be affected by massage)

Provider's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Extension: \_\_\_\_\_

Permission to Consult with Primary Provider? No \_\_\_ Yes \_\_\_ (please initial here if yes) \_\_\_\_\_

2. Please check if you have any of the following conditions:

- |                                   |                       |   |
|-----------------------------------|-----------------------|---|
| - Recent injury                   | - Diabetes            | - Phlebitis                             |
| - Recent illness                  | - Kidney problems     | - Varicose veins                        |
| - Recent surgery                  | - High blood pressure | - Other circulatory/heart/lung problems |
| - Chronic pain                    | - Blood clots         | - Contagious skin disorders             |
| - Joint problems                  | - Wear contact lenses | - Cancer or undiagnosed growths         |
| - Chronic illness/health problems |                       | - Pregnancy                             |

**Please note** that Massage is not recommended for certain health conditions - I.E. circulatory problems, contagious conditions, etc. Depending on the condition and its severity it may be necessary for us to consult with your Provider prior to any massage work. If you have questions or concerns about your health condition and how massage might affect you **please** consult with your Health Care Provider.

3. Do you have any Allergies to Oils or Lotions? \_\_\_\_\_

4. Are you taking any medications? If so, please indicate what kind \_\_\_\_\_

5. History of injuries, illnesses and/ or surgeries (please include *approximate* dates and treatment received):

\_\_\_\_\_  
\_\_\_\_\_

6. Of the following areas, circle any areas where you have experienced pain within the past year:

Headaches	Back	Chest	Abdomen	Hip	Leg
Shoulder	Neck	Arm	Pelvis	Groin	Buttock

7. What are the main sources of stress in your life? \_\_\_\_\_

8. Where in your body do you feel the effects of stress? \_\_\_\_\_

9. What do you do for relaxation? \_\_\_\_\_

10. What do you do for exercise? \_\_\_\_\_

11. How do you rate your overall health?   Excellent                      Good                      Fair                      Poor

12. Have you ever experienced a professional massage or bodywork session? \_\_\_\_ How recently? \_\_\_\_\_

13. What are your expectations for our massage work? \_\_\_\_\_

14. Please indicate below the areas of your body that you give permission to receive massage. **Y** = Yes, **N** = No.

(Client may verbally Add or Revoke permissions at any time before or during sessions but permissions added after the fact need to be documented here and initialed by the client. Permissions don't guarantee an area will be worked on. To be clear: "Buttocks" as used here includes the large muscle area from the low back below the Iliac crest to the ham string attachments and from the sacrum to the hip bone. Client should discuss any partial permissions with the therapist.)

Back\_\_\_\_      Legs\_\_\_\_      Glutes/Hip/Buttocks\_\_\_\_      Arms\_\_\_\_      Abdomen\_\_\_\_      Chest\_\_\_\_

Neck\_\_\_\_      Head\_\_\_\_      Face\_\_\_\_      Feet\_\_\_\_      List Any Area(s) Specifically Requested:

(example: Left hip, right shoulder) \_\_\_\_\_

15. You are in control of your massage session. Please communicate with the therapist during the massage regarding any personal or physical discomfort resulting from any of the following: Pain levels (1-10), modalities used, degree of draping, pressure of strokes, room temperature or quantity of lotion/oil.

\* In case of emergency, Please Notify:

Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

\*Please refrain from wearing Fragrances during your massage. \*A bowl is provided for Jewelry & small items.

\*Please turn off your Cell Phone. \*Indicate on the figures on page 3 any current areas of pain and discomfort.

\*Please read and sign below: "It is my choice to receive massage therapy. I realize that the treatment is being given for the well being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well being is being compromised. I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I give permission for the therapist to consult with my physician(s) as needed and to share my information sufficient to process any insurance claims. I have stated all medical conditions that I am aware of and will update the therapist of any changes in my health status."

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_