Freedom to Move Massage Therapy

Gina C. James, LMT
1832 NE Broadway< Portland, OR, 97232~503.282.8600 (ph)~503.287.0967 (fax)

Personal Health Information

PERSONAL INFO

Name: ____________________ Date: __________ Email: ____________________

Referred By: ____

Address: ____________________ Phone (day): ____________________

City/State/Zip: ____________________ Phone (eve): ____________________

Birthday: ____________________ Occupation/Employer: ____________________

Primary Health Care Provider: ____________________ Phone: ____________________

Permission to consult with primary provider? If yes, please initial. ◊ YES __________ ◊ NO

Emergency contact/Relationship: ____

MASSAGE HISTORY/TREATMENT INFORMATION

Have you ever received a professional massage? ◊ YES ◊ NO Frequency: ________ Last massage: ________

What results do you want from your massage sessions ____________________

____

____

Prioritize the areas of your body that you would prefer to be massaged: ____________________

____

____

Please check the areas of your body that you give permission to receive a massage:

◊ Back ◊ Legs ◊ Buttocks ◊ Arms ◊ Abdomen ◊ Chest ◊ Neck ◊ Head ◊ Face ◊ Other

Are you currently seeing a medical practitioner? If yes please explain. ____________________

____

____

Are you currently seeing a psychotherapist or attending regular support group meetings? If yes please explain. ◊ Y ◊ N

____

____

List stress reduction and exercise activities. Include frequency. ____________________

____

____

List current medications, including aspirin, ibuprofen, etc. ____________________

____

PREVIEW HISTORY (Include year and treatment received)

Surgeries: ____

____

____

Accidents: ____

____

____

HEALTH HISTORY

Musculo-Skeletal

____ bone or joint disease ____________
____ tendonitis ____________
____ bursitis ____________
____ broken/fractured bones ____________
____ arthritis ____________
____ sprains/strains ____________
____ low back, hip, leg pain ____________
____ neck, shoulder, arm pain ____________
____ headaches/head injuries ____________
____ spasms/cramps ____________
____ jaw pain/TMJ ____________
____ lupus ____________
____ other ____________

Circulatory

____ heart condition ____________
____ varicose veins ____________
____ blood clots ____________
____ high blood pressure ____________
____ low blood pressure ____________
____ lymphedema ____________
____ breathing difficulty ____________
____ sinus problems ____________
____ allergies ____________
____ other ____________

Infectious Disease

____ disease name(s) ____________

____

____

____

Skin

____ allergies ____________
____ rashes ____________
____ athletes foot ____________
____ warts____________
____ other____________

Digestive

____ constipation____________
____ gas/bloating____________
____ diverticulitis____________
____ irritable bowel syndrome ____________
____ other____________

Nervous System

____ herpes/shingles ____________
____ numbness/tingling____________
____ chronic pain____________
____ fatigue ____________
____ sleep disorder(s) ____________
____ other____________

Reproductive

____ pregnant? Stage? ____________
____ PMS____________
____ other____________

Other

____ cancer/tumors____________
____ diabetes____________
____ eating disorder(s) ____________
____ depression ____________
____ drug/alcohol addiction____________
____ nicotine/caffeine addiction____________

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 practitioners do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner or any changes in my health status.

Signature: ______________________________ Date: ____________________