Jennifer Pumpelly LMT OR #12000

Southwest Physical Therapy
11910 SW Greenburg Rd.
Tigard, OR 97223

Massage Intake Form

Name _____ Date of Birth_____

Email _____ Phone _____

Address _____ City _____ State _____

Zip _____ Occupation_____

Emergency Contact Name and Phone: _____

_____

How did you hear about us? _____ If you were referred by a Doctor or clinic, please provide their name _____

The following information will be used to help plan safe and effective massage sessions. Please answer these questions to the best of your knowledge.

Have you had a professional massage before? Y | N

If yes, how often do you receive Massage Therapy? _____

Do you have any trouble lying on your front, back, or side? Y | N

If yes, please elaborate _____

Do you sit for long hours at a workstation or computer, or driving? Y | N

If yes, please elaborate _____

Do you perform any repetitive movement in your work, sports, or hobbies? Y | N

If yes, please elaborate _____

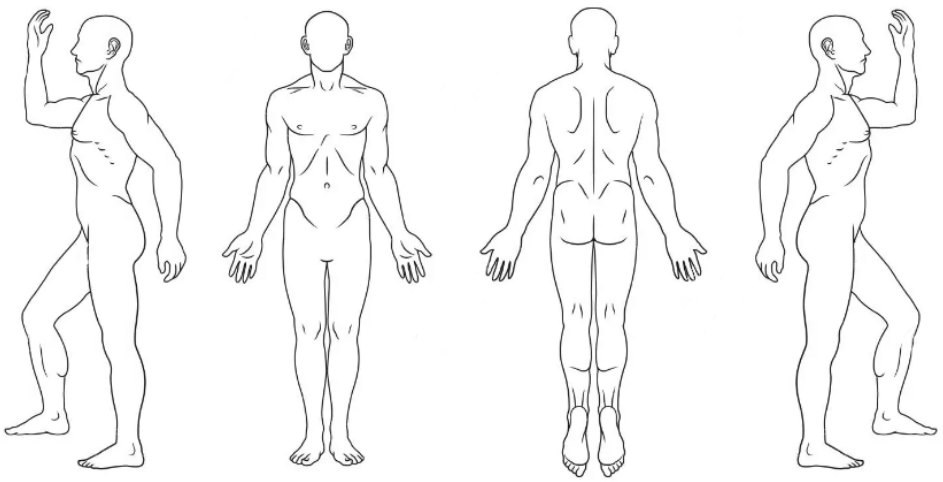
Do you have any particular goals in mind for this massage session? Y | N

If yes, please elaborate _____

Is there a particular area of the body where you are experiencing tension, stiffness, pain, numbness, or other discomfort? Y | N

If yes, please elaborate _____

Please identify any areas of pain by marking X, and any areas of stiffness by marking S



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Medical History:

Are you currently under medical supervision? Y | N

If yes, please elaborate _____

Do you see a Chiropractor? Y | N

If yes, how often?_____

Please list all medications you are currently taking, including supplements, birth control, and over-the-counter medications _____

_____

_____

Please look over the list below and check all that apply past and present

▢ Bone or Joint Disease	▢ Depression
▢ Allergies	▢ Anxiety
▢ Tendonitis	▢ Endometriosis
▢ Rashes	▢ Varicose Veins
▢ Bursitis	▢ Cancer/ Tumors
▢ Athletes Foot	▢ PMS/ PMDD
▢ Broken/Fractured Bones	▢ Diabetes/ Type: _____
▢ Warts	▢ Infectious/ Blood-borne Diseases
▢ Arthritis	▢ Lymphedema
▢ Constipation	▢ High/Low Blood Pressure
▢ Neck/ Shoulder/ Arm Pain	▢ Bruise Easily
▢ Low Back/ Hip / Leg Pain	▢ Drug/ Alcohol Disorder
▢ IBS	▢ Sinus Problems
▢ Fatigue	▢ Blood Clots
▢ Headaches/ Head Injury	▢ Breathing Difficulties
▢ Herpes/ Shingles	▢ Heart Conditions/ Disease
▢ Sleep Disorder	▢ Asthma
▢ Spasms/ Cramps	▢ Chronic Pain
▢ TMJ/ Jaw Pain	▢ Thyroid Issues (Hypo/Hyper)
▢ Sprains/ Strains	▢ Fibromyalgia/ Myofascial Pain Syndrome

Please elaborate if needed on any items checked above _____

_____

Is there anything else about your health history you would like us to be aware of? _____

_____

Consent for Treatment: PLEASE TAKE A MOMENT TO CAREFULLY READ THE FOLLOWING INFORMATION AND SIGN WHERE INDICATED

I understand that the information I have provided will be held in the strictest confidence and that I have the right to view my records upon written request. I further understand that the massage therapy I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. If I experience any pain or discomfort during any session, I will immediately inform the massage therapist so the pressure and/or strokes can be adjusted to my level of comfort. I understand that Massage Therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapists part should I fail to do so. Should I need to cancel future sessions, I agree to give my massage therapist 24 hours notice or I may be financially responsible for all or part of the session cost.

Signature: _____ Date:_____

Parent/Guardian Signature if under 18 _____