SW PHYSICAL THERAPY

503 - 597 - 1151
SWPHYSICALTHERAPY.COM
11910 SW GREENBURG RD
TIGARD, OR 97223

Name (Last) _____(First) _____Phone _____

Address _____City _____State_____Zip _____

Date of Birth_____Occupation_____ Emergency Contact Name and Phone _____ Email _____

How did you hear about us? internet, advertisement, referral, etc. _____

If you were referred, please provide their name so we may thank them._____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge by circling Yes or No.

1. Have you had a professional massage before? **Yes No**

If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back, or side? **Yes No**

If yes, please explain. _____

3. Do you sit for long hours at a workstation, computer, or driving? **Yes No**

If yes, please describe. _____

4. Do you perform any repetitive movement in your work, sports, or hobby? **Yes No**

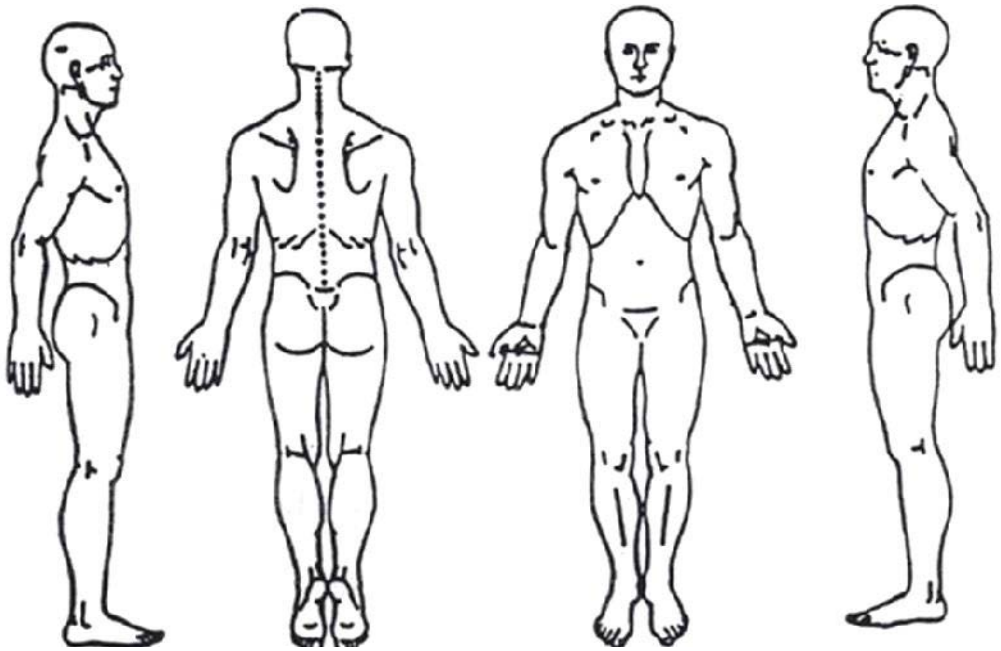
If yes, please describe. _____

5. Do you have any particular goals in mind for this massage session? **Yes No**

If yes, please explain. _____

6. Is there a particular area of the body where you are experiencing tension, stiffness, pain, numbness, or other discomfort? **Yes No**

If yes, please identify by placing an **X** on areas of pain, and an **S** on any areas of stress or tension.



KEEPMOVINGFORWARD@SWPHYSICALTHERAPY.COM

Updated: 6/24/13 MRV

Medical History:

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

1. Are you currently under medical supervision? **Yes** **No**

If yes, please explain. _____

2. Do you see a chiropractor? **Yes** **No** If yes, how often? _____

3. Are you currently taking any medication? **Yes** **No**

If yes, please list. _____

4. Please check any condition listed below that applies to you: ( ) contagious skin condition

( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) Bursitis
( ) Atherosclerosis
( ) Phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) Osteoporosis
( ) Epilepsy
( ) headaches/migraines
( ) Cancer
( ) Diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) golfer's elbow
( ) Scoliosis
( ) pregnancy If yes, how many months? _____

Please explain any condition that you have marked above, or have been diagnosed with but are not listed.

_____

_____

5. Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? _____

_____

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 that the pressure and or strokes may 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 therapist's part should I fail to do so. Should I need to cancel future sessions, I agree to give my massage therapist a 24 hour notice or I may be financially responsible for the

session time

Signature of Client _____ Date _____

Signature of Client's Parent or Legal Guardian if under 18 _____ Date _____

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