SW Physical Therapy
11910 SW Greenburg Rd.
503-597-1151
Jennifer Pumpelly LMT OR #12000

Massage Intake Form

Name: _____ Date of Birth: _____

Phone: _____ Cell #: _____

Email Address: _____

Address: _____ City: _____ State: _____

Zip: _____ Occupation: _____

Emergency Contact Name and Phone:
_____

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

If you were referred by a Dr. or clinic, 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. _____

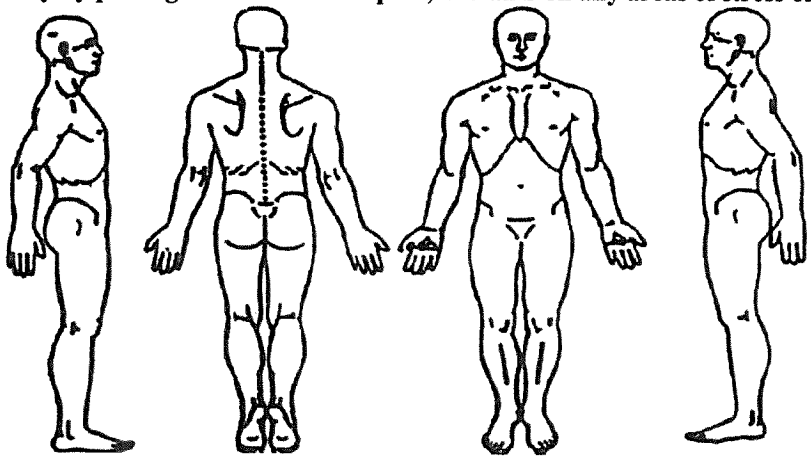
3. Do you sit for long hours at a workstation, computer, or driving? **Yes No**
If yes, please describe. _____

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 explain
_____

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



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. _____

Please look over the list of health disorders and check all that apply.

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

If you checked any disorders or diseases above, please use the next few lines to explain. (Example: dates, areas of disorder/disease
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?
_____

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 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:** _____
updated 3/2021