Gresham Balance Bodyworks, LLC
Lindsay Lindala, LMT #13478 - Danielle Sutton, LMT #19777

Confidential Health History Information

Name ____ Date ___/___/___
Address ____
City/State/ZIP ____
Best phone # to reach you ________________________________ (H) (W) (C)
E-mail ____
M F Birth date _______________ Occupation ________________________
How did you hear about me? ______________________________________
Emergency contact _________________________ Phone ________________

Have you received a professional massage? ______ How Often? ___________

What is your desired result from your massage? ___________________________

Chief complaint: ____

When did these symptoms begin? ______________________________________

Other treatments you have received recently (Circle all that apply):
Medical/Naturopathic Acupuncture Chiropractic Physical Therapy
May I consult with your practitioner(s)?_____________ Initial ____________
Name/Title: __________________________________Phone _____________

Please list any medications: ____

Please list any allergies (lotions, scents, other): ___________________________

Are you pregnant? __________ Due ______________________________________

Self care activities?____

Where do you hold your stress? _______________________________________

Any skin conditions? Contagious? _____________________________________

Please list any major injuries or surgeries within the past 5 years (including implants): ____

For Ashiatsu: For safety/liability reasons, there may not be anyone over 300 lbs on the massage table. Please inform your practitioner if you have any concerns.

22400 SE Stark St, Gresham, OR 97030 - ph: 541-510-8476 - fax: 503-907-0098

Please mark (x) by all current conditions and (P) for all past conditions

__ Anxiety	__ Diabetes type ___	__ Jaw pain (TMJ)
__ Asthma/lung condition	__ Digestive problems	__ Joint pain/stiffness
__ Arthritis/tendonitis	__ Disc problems	__ Low blood pressure
__ Blood clots	__ Edema/swelling	__ Lymphatic condition
__ Bone condition	__ Fatigue	__ Numbness/tingling
__ Cancer	__ Fibromyalgia	__ Sinus problems
__ Chronic pain	__ Headaches/migraines	__ Sleep difficulties
__ Circulatory/heart problems	__ Hearing problems	__ Spinal disorders
	__ Hernia	__ Varicose Veins
__ Depression	__ High blood pressure	__ Vision problems

Please explain any condition that you have marked above: ___________________

____

Is there anything else about your health history that you think would be useful for your massage practitioner to know? ___________________________________

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Assignment and Informed Consent:

I have chosen to receive massage therapy for the well being of my body, mind, and spirit. I agree to communicate with my therapist any time I feel my wellness is being compromised. Massage therapists do not diagnose illness, disease, or mental disorder; they also do not prescribe medical treatment, pharmaceuticals or perform spinal thrust manipulations. All information I have provided on this form is true and accurate to the best of my knowledge. I agree to update my therapist on personal, health, or other information my therapist may need to conduct treatment safely and effectively. I also agree there shall be no liability on the practitioner's part should I neglect to do so. I understand that massage therapy is a therapeutic health aide and is non-sexual. I have been given the chance to read the HIPAA Privacy Policies Notice and offered a copy for my own records. I understand that my private health information will be used only for conducting, planning and directing my treatment, consulting with other health care providers who may be directly or indirectly involved in my treatment, or obtaining payment from third-party payers.

Signature: ____Date: ____/____/____

Relationship to patient: ________________________________

Cancellation Policy

Our time together is important. Unless you have an emergency, please cancel your appointment 24 hours in advance or pay the missed appointment fee in full.