

Massage Solace
Sarah Schlamp, LMT
License # 15785
503.756.9365

Intake

Please print

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Date of birth _____ Occupation _____ E-mail _____

Phone #'s (Hm) _____ (Wk) _____ (Cell) _____

Emergency Contact _____ Phone _____

Health Related Questions

What are your typical daily activities? _____

Do you perform any repetitive movement in your work, sports, or hobby? Please explain. _____

Do you have any difficulty lying on your front, back, or side? Please explain. _____

Are you currently under the care of a doctor? _____ For: _____

What prescriptions are you currently taking, and what are they for? _____

How recent was your last dose? _____

Please indicate what applies to you now (N), and in the past 5 years (P), including types & approximate dates:

<u>Injuries</u>	<u>Dates</u>	<u>Conditions</u>	<u>Dates</u>
<input type="checkbox"/> Broken Bones	_____	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Falls	_____	<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Head Injuries	_____	<input type="checkbox"/> Circulatory Problems	
<input type="checkbox"/> Motor Vehicle Accidents	_____	<input type="checkbox"/> Decrease/Loss of Sensation	
<input type="checkbox"/> Sports Injuries	_____	<input type="checkbox"/> Deep Vein Thrombosis/Blood clots _____	
<u>Diseases</u>		<input type="checkbox"/> Cleared _____	
<input type="checkbox"/> Autoimmune Diseases		<input type="checkbox"/> Fibromyalgia &/or Chronic fatigue	
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Headaches/Migraines	
<input type="checkbox"/> Communicable Diseases		<input type="checkbox"/> High/Low Blood Pressure	
<input type="checkbox"/> Contagious Skin Conditions		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Open sores or wounds	
<input type="checkbox"/> Heart, Lung, Kidney Diseases		<input type="checkbox"/> Painful Periods/Cycles	
		<input type="checkbox"/> Post Traumatic Stress Disorder	

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Please list surgeries and dates: _____

Is there any other health related condition that wasn't mentioned? _____

Briefly explain: _____

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified specialist for any mental or physical ailment that I am aware of. 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.

Please read and initial.

I understand that I am ultimately responsible for payment regardless of insurance coverage. _____

I understand I will be charged the full amount of my appointment if I don't give at least 24 hrs notice of cancellation or if I don't show up to my appointment. _____

I understand that this office is HIPPA compliant, which means my information will not be shared with anyone unless authorize it. _____

I authorize my massage therapist to talk about my care with professionals I tell her about. _____

I understand my massage therapist is not a doctor, counselor, or mind reader. I agree to communicate my needs and seek other professional help when I am in need of such. _____

Client Signature _____ Date _____

For clients under the age of 18, consent must be signed by parent or legal guardian.

Parent signature _____ Date _____