New Client Information

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Email: _____ Please send me your newsletter: ❑ Yes ❑ No
Date of Birth: _____ Employer/Occupation: _____
Who may we thank for referring you? _____
Referring Physician: _____ Phone: _____
Emergency Contact: _____ Phone: _____

What is your primary objective for seeking bodywork today? _____
Have you ever had a professional therapeutic massage? ❑ Yes ❑ No How long ago? _____
Have you ever had cranio-sacral therapy? ❑ Yes ❑ No How long ago? _____
Are there any areas of your body that you would like avoided altogether? _____

Do you suffer from any of the following:
❑ Stress: frequency _____
❑ Headaches: frequency _____
❑ Sleep difficulty _____
❑ Dizziness _____

Please mark any areas of numbness, dysfunction, discomfort, tingling, pins and needles, burning, aching, stabbing pain, spasm, stiffness, or preferred area(s) of focus, and describe:

_____
_____
_____
_____
_____
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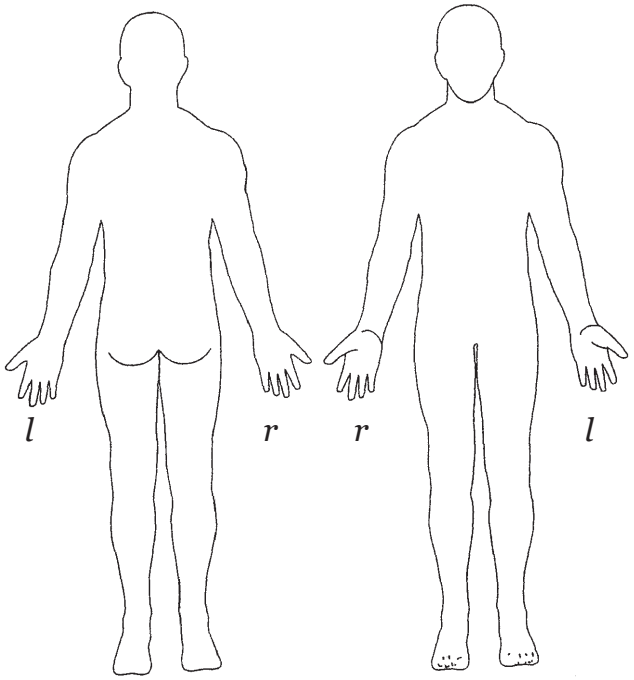
_____



How to rate your symptoms on a pain scale of one to ten:

10 The pain is intense, constant, greatly restricts your activities, and it is impossible to go more than 5 minutes without awareness of the pain.
9 The pain is intense, constant, greatly restricts your activities, but you can forget about the pain for up to 15 minutes at a time.
8 The pain is significant, moderately intense at times, but not constant. Most activities are affected, and you think about it once or twice an hour.
7 The pain is significant at times, but never intense and not constant. Most activities are affected, and you think about it once or twice an hour.
6 The pain is moderate, yet too frequent to ignore. Some activities are affected. Hours can go by without being aware of the pain.
5 The pain is moderate, yet too frequent to ignore. Almost no activities are affected. Hours can go by without being aware of the pain.
4 The pain is little more than a nuisance, and you go through your whole day frequently aware, but not really affected by it.
3 The pain is little more than a nuisance, your awareness of the pain may be absent for a whole day at a time, and you are never affected by it.
2 At it's worst, the pain is best described as uncomfortable. Days can go by without being aware of it.
1 At it's worst, the pain is best described as uncomfortable. Your symptoms do not recur more frequently than once a week.

Medical History

yes no

❑ ❑ Are you wearing medical devices? ❑ Contacts ❑ Dentures ❑ Hearing Aid ❑ Other_____

❑ ❑ Do you suffer from any of the following?

❑ Skin disorders: ❑ Rash ❑ Yeast ❑ Fungus ❑ Psoriasis ❑ Infection ❑ Other_____

❑ Allergies: ❑ Latex ❑ Peppers ❑ Oils ❑ Nuts ❑ Skin care ingredients ❑ Other _____

❑ ❑ Are you under the care of a physician for any reason? Please explain _____

❑ ❑ What medications are you taking and when was your last dose? _____

❑ ❑ Any recent/current illnesses? ❑ Infectious ❑ Viral ❑ Bacterial ❑ Other _____

❑ ❑ Have you ever been diagnosed with any of the following conditions?

❑ Arthritis. Type and location(s)_____

❑ High blood pressure ❑ Low blood pressure ❑ Aneurism ❑ DVT ❑ Other _____

❑ Heart Disease

❑ Diabetes: ❑ Type I ❑ Type II (Adult Onset) ❑ Other _____

❑ Cancer. Type and location(s) _____

❑ Spinal condition: ❑ Scoliosis ❑ Osteoporosis ❑ Other _____

❑ Asthma ❑ Other medical condition(s) _____

Date(s) of diagnosis of any of the above conditions _____

❑ ❑ Have you ever had surgery?

Affected area of the body _____ Date/Year(s) _____

❑ ❑ *Menstrual cycle issues:* ❑ *Pain/Cramping* ❑ *Irregularity* ❑ *Other* _____

❑ ❑ *Are you now pregnant? What trimester?* _____ *Any complications?* _____

❑ ❑ Do you have any needs that require special attention? _____

❑ ❑ Do you have any questions before we get started? _____

General Understanding

I understand that Orthopedic Massage Therapy and other related health care services from this office are not in any way to be used instead of or in place of consulting a Physician for diagnosis and treatment of any physical symptoms, but to be used in conjunction with, or on the advice, referral, or prescription of, my Physician(s).

_____ Please initial

I understand that my scheduled appointments are reserved exclusively for me. I agree to call my therapist as soon as I know I cannot keep an appointment. All missed appointments, and cancellations made after 5pm the business day preceding any scheduled appointment, will be billed at $50.00 per hour for the time reserved. I agree to be responsible for these charges, and I will make payment at or before the time of my next visit. I understand that this policy is in place to assist Oregon Clinical Massage and my therapist in providing the best possible care to me and all others who choose to use this clinic's services. _____ Please initial

By my signature, I verify that all information provided is true and correct to the best of my knowledge. I promise to keep my therapist updated on any changes in my health and residence. I understand that in the therapy session(s) my comfort level will always come first and that I, or the therapist, may request the treatment to stop or change for any reason. I agree to payment at the time of service by cash or check. I agree to pay a $25 fee for any returned NSF checks.

Patient (or Guardian's) Signature _____ Date _____