

**Motion Massage**

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**Confidential Client Information**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact and their relationship to you:

\_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

Occupation: \_\_\_\_\_ Referred by? \_\_\_\_\_

**Health Information**

Are you currently under the care of a health care practitioner for any reason? Y / N

If yes, briefly explain: \_\_\_\_\_

Health practitioner's name: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

Please check if you have any of the following conditions:

- High/Low Blood Pressure?
- Heart Conditions/Pacemaker?
- Diabetes?
- Cancer/Tumors?
- Jaw pain/Teeth Grinding/TMJD?
- Muscle or Joint Pain?
- Sinus Problems?
- Kidney Problems?
- Sleep Difficulties?
- Depression?
- Circulatory/Blood Clotting Disorders?
- Varicose Veins?
- Numbness or Altered Sensation?
- Allergies?
- Chronic Pain?
- Sprains/Strains?
- Vision Problems?
- Skin Problems?
- Nausea?
- History of Sexual Abuse?
- Epilepsy/Seizures?
- Arthritis?
- Headaches?
- Scoliosis?
- Tendonitis?
- Wear Contacts?
- Digestive Problems?
- Fatigue?
- History of Physical Abuse?

*Women only:*  Pregnancy?  Endometriosis?

Fibroids/Ovarian Cysts?  Painful or Irregular Menstruation?

*Men only:*  Prostate Problems?

Have you been in a recent or major accident, or suffered any recent or major injuries? Y / N

If yes, briefly explain (what and when): \_\_\_\_\_

Have you had recent or major surgery? Y / N If yes, briefly explain (what and when): \_\_\_\_\_

-Please turn page-

Are you currently suffering from any chronic or acute infectious/contagious disease? Y / N

If yes, which: \_\_\_\_\_

Are you currently taking any medications (prescription and non-prescription)? Y / N

If yes, name(s) of medication(s): \_\_\_\_\_

Do you have any other medical condition not specified above? Y / N

If yes, briefly explain: \_\_\_\_\_

Have you ever experienced professional massage, bodywork, or therapeutic movement before? Y / N

If yes, how often? \_\_\_\_\_ How recently? \_\_\_\_\_

Would you like me to focus on, and/or stay away from any specific area(s)?

What are the main sources of stress in your life? \_\_\_\_\_

How does stress affect your body/mind/spirit? \_\_\_\_\_

What do you do for relaxation and/or exercise? \_\_\_\_\_

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Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition, or specific symptoms, massage, bodywork, and therapeutic movement may be contraindicated. A referral from your primary care provider may be required prior to service being offered.

It is my choice to receive these sessions. If I experience any discomfort during the sessions I will immediately inform the practitioner, so that the treatment may be adjusted to my level of comfort.

Because massage, bodywork, and therapeutic movement 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 practitioner updated as to any changes in my medical profile, and I understand that there shall be no liability on the practitioner's part should I fail to do so.

I further understand that massage, bodywork, and therapeutic movement should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage, bodywork, and therapeutic movement practitioners 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. Information exchanged during any session is educational in nature and is intended to help me become more familiar and conscious of my own body and my state of being.

I am responsible for all charges for the services provided.

I understand that appointment times are reserved especially for me, and that **24 hours** notice is required for all cancellations and changes, except in case of an emergency. If I fail to do so, I agree to pay the **full** appointment fee.

Signature \_\_\_\_\_ Date: \_\_\_\_\_