



TRUE NORTH MASSAGE

Sheila Resari, LMT #12784
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www.truenorthmassage.com

Confidential Information

Name _____ Date of initial visit _____

Address _____

Primary Phone _____ Alternate Phone _____

Email _____ Referred By _____

Date of Birth _____ Age _____ Occupation _____

Emergency Contact _____ Phone _____

Reason for Visit

Primary reason for visit _____

When did you first notice it? _____ What brought it on? _____

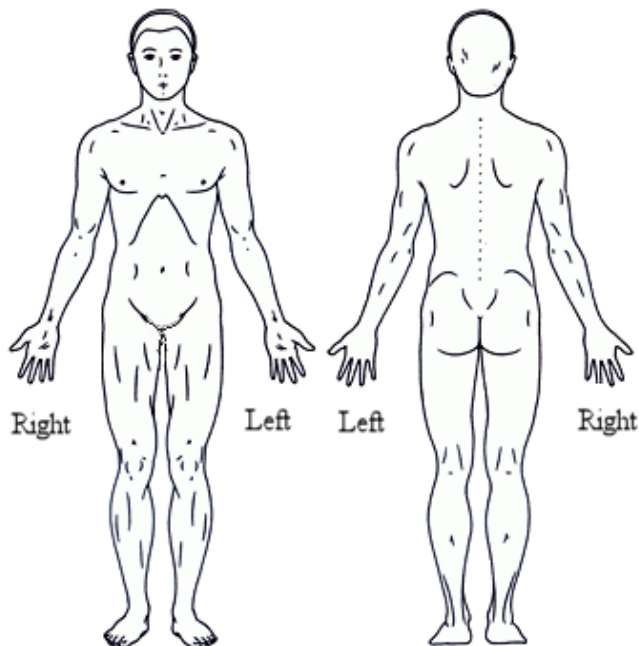
Describe any stressors occurring at the time _____

What activities provide relief? _____ What makes it worse? _____

Is this condition getting worse? _____ Interfere with work _____ sleep _____ recreation _____

Is this visit related to a work-related injury or auto accident? Work Auto Neither

Please list, in order of importance, any other reasons you are here today _____



Mark your sensations on the picture:

Numbness = = = Sharp/Stabbing ///
Dull Ache OOO Pins, Needles +
+ +
Burning XXX Other _____ ^^ ^

Circle degree of discomfort: 0 none, 10 severe

0 1 2 3 4 5 6 7 8 9 10



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Medical History

Are you under the care of another health care provider(s)? _____ Reason (s) _____

Name (s) of Practitioner _____ Phone _____

Insurance carrier _____ Plan number _____

Have you had massage before? _____ What type(s)? _____

Current Medications/Supplements _____

Any noticeable side effects? _____

Allergies/Sensitivities: specify allergen and reaction _____

Any Illness, Injury, Surgery, or Trauma in past 3 years or that still affects you (date, treatment, status):

Mark any conditions you have currently or have experienced recently (past year):

GENERAL

- Dizziness
- Fainting
- Headache/Migraines
- Sleep Disorder
- Fatigue

MUSCLES & JOINTS

- Muscle Cramps
- Swollen Joints
- Painful Joints
- Stiff Joints
- Joint Replacement
- Joint Instability
- Sore Muscles
- Weak Muscles
- Sprains/Strains
- Broken Bones
- TMJ Issues
- Disc Problems
- Scoliosis
- Arthritis
- Osteoporosis

GENITO-URINARY

- Kidney Infection
- Kidney Failure
- UTI
- Bladder Control Loss
- Painful Periods
- Currently Pregnant
- IUD

NERVOUS SYSTEM

- Numbness/Tingling
- Shooting Pain
- Sciatica
- Depression
- Anxiety
- Confusion
- Loss of Memory

RESPIRATORY

- Asthma
- Bronchitis
- Common Cold
- Flu

CARDIO-VASCULAR

- High Blood Pressure
- Low Blood Pressure
- Heart Condition
- Chest Pain
- Poor Circulation
- Strokes
- Anemia
- Edema
- Varicose Veins
- Blood Clots
- Phlebitis
- Aneurysm

GASTRO-INTESTINAL

- IBS
- GERD
- Hepatitis
- Constipation
- Diarrhea
- Nausea
- Abdominal Pain
- Ulcer

SKIN OR ALLERGIES

- Boils
- Scar Tissue
- Acne
- Bruising Easily
- Eczema/Dermatitis
- Rash
- Psoriasis
- Warts
- Fungus
- Itching
- Sensitive Skin
- Cut/Bruise/Burn
- Herpes
- Other Contagious Condition

OTHER

- Cancer
- Tumors
- Epilepsy
- Diabetes
- Chronic Pain

I verify that all of the information provided is correct and current to the best of my knowledge and will inform my practitioner of any changes in my health.

Signature: _____

Date: _____



Massage Policies

Please read the following statement carefully, then sign and date at the bottom.

- I take responsibility to update any pertinent health or contact information during future visits. I take responsibility for my personal belongings.
- I understand that the therapist does not diagnose, treat, or prescribe for any illness, ailment or disease, nor do spinal adjustments. Massage is not a substitute for medical examinations and/or diagnosis, and I should see a physician if needed.
- I am aware that this is a non-sexual massage. Any misconduct or inappropriate behavior will result in immediate termination of the massage with full payment due. I understand that I will be fully covered with a sheet (known as a “drape”) at all times and only the body part being worked on will be uncovered.
- I understand that I am in control of my session and can stop at any time; I will comment on my comfort or discomfort regarding pressure, technique, or area. I understand that for my own safety and my therapist’s, it is unacceptable to receive bodywork while under the influence of alcohol or illicit drugs.
- If I running late for an appointment, I agree to call as soon as possible; I understand that my time may be shortened as a result. I understand that 24 hours notice of cancellation is required. For a late cancellation or missed appointment, I will be responsible for a **\$30 fee**.
- It is my responsibility to pay for all services provided. In the event that my insurance company denies payment or makes a partial payment, I am **responsible for the balance**. By paying for my session at the time of service, I qualify for a time-of-service discount.
- I acknowledge that I received this office’s Notice of Privacy Practices, which describes my privacy rights and how my health information may be used or disclosed.
- The areas I feel **comfortable** receiving massage include:

Scalp	Abdomen	Thighs (quads/hams)	Neck
Face	Arms	Lower Legs	Back
Upper Chest (pecs)	Hands	Feet	Glutes (butt/hips)

Client Signature _____

Date _____