

# Healthy Body Massage Therapy

**Heidi Valles LMT NBTMB \* 530 NE E St - Grants Pass, Oregon 97526 \* (541) 659-9321**

Welcome Intake Form and Confidential Client History Please fill in every box.

Name	Date of Birth <span style="float: right;">Age</span>
Address	Occupation
City State Zip	Physician
Phone Home/Cell	Emergency Contact
Email Address	Emergency Phone

Are you presently experiencing pain, where? \_\_\_\_\_

What style of massage are you seeking? Relaxation / Pain Relief

Last visit to a doctor or massage therapist? Name: \_\_\_\_\_ Date: \_\_\_\_\_

What was treatment for? \_\_\_\_\_

How do you use your body on a daily basis? Please circle all that apply:

Sitting, Walking, Driving, At a Computer, Thinking, Lifting, Playing, Traveling, Housework

Do you have any of the following?	Circle word = present	Check = past
<input type="checkbox"/> Sprains/ strains	<input type="checkbox"/> Numbness	<input type="checkbox"/> Cancer
<input type="checkbox"/> Fractures/Breaks Where _____	<input type="checkbox"/> Surgeries: If yes When _____	<input type="checkbox"/> Low/High blood pressure
<input type="checkbox"/> Injuries Type _____	<input type="checkbox"/> Skin rash	<input type="checkbox"/> Numbness in feet
<input type="checkbox"/> Headaches	<input type="checkbox"/> Eczema	<input type="checkbox"/> Circulation problems
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Open sores or wounds	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Frozen Shoulder
<input type="checkbox"/> Arm pain	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Hand pain	<input type="checkbox"/> Heart condition	<input type="checkbox"/> Depression
<input type="checkbox"/> Back pain	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Leg pain		<input type="checkbox"/> Other _____
<input type="checkbox"/> Foot pain		

Is your pain from an auto accident at work injury? Yes / No If yes, please explain:  
Date: \_\_\_\_\_ What kind of treatment did you receive? \_\_\_\_\_

Who can I thank for referring you to Healthy Body Massage? \_\_\_\_\_

Website Business Card Friend Family Co-worker Client Yellow Pages Google Search

**Please read and sign:**

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder, nor prescribe medical treatment. I acknowledge that massage is not a substitute for medical examinations or diagnosis, and that it is recommended that I see a primary health care provider for that service. Payment is due at time of service. I have read, understand and agree to the above policy.

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