THAI MASSAGE PDX

Name_____ Date of Birth _____

Address _____ Zip Code_____

Email_____ Phone Number _____

Occupation_____ Today's Date _____

Emergency Contact Name_____ Emergency contact phone_____

Have you received massage/bodywork before? Yes / No

If yes, what type and how often?_____

Please list any ongoing or current aches and pains _____

_____

Have you ever had any accidents, serious injuries, illnesses, or major surgeries? Please describe and include dates:_____

_____

_____

What are you hoping to get from this bodywork session?_____

_____

Are there any areas on your body that should be avoided? _____

What positions are you frequently in due to lifestyle, work or habitat? (i.e. sitting at a desk, driving, etc.)

_____

Are you currently under the care of a physician? If yes, please list name and reason/ treatment: _____

_____

If you exercise or stretch regularly, please list what type and how often. _____

_____

Please see reverse side >

Please check any of the following that apply to you. You will have a chance to elaborate during intake.

- ❑ Circulation Issues
- ❑ Gastrointestinal Issues
- ❑ Heart Disease
- ❑ High/Low Blood pressure
- ❑ Open cuts, bruises, etc.
- ❑ Pregnant due date:_____
- ❑ Allergies
- ❑ Easy Bruising
- ❑ Osteoporosis
- ❑ High Stress
- ❑ Constipation
- ❑ Anxiety
- ❑ Cancer
- ❑ Illness
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Chronic Fatigue
- ❑ Depression
- ❑ Arthritis
- ❑ Varicose Veins
- ❑ Numbness/Tingling
- ❑ Headaches
- ❑ Recent Surgery
- ❑ Other

Massage Liability Release

Massage is not intended to cure, diagnose or treat any medical conditions and should not replace treatment or consultation by qualified physician or therapist.

You are in complete control of your massage session. If at any time you feel uncomfortable, headache, dizziness, muscle soreness, bruising, allergic reaction to herbal products or any other intolerable pains, please inform your therapist so they can correct the situation or discontinue the massage. By signing this release you agree not to hold your therapist liable for any adverse effects of any treatments given to you. For your safety please be sure to fill out the intake form accurately.

By signing this form you acknowledge that you have read and agree to the above.

Name _____ Date_____