Oregon Massage and Wellness Clinic
415 17th St Suite 8 Oregon City, OR 97045
5003-467-1561 Chelle@ccgmail.net

Massage Therapy Intake Form

Name:_____ Date of Birth:_____
Home Phone: ( )_____Work Phone: ( )_____Cell Phone: ( )_____
E-mail address:_____
Address:_____City:_____St:_____Zip:_____
Referred by:_____ Have you ever had a professional massage before?_____
If so, how often?_____ Do you exercise?_____ Frequency:_____
Please describe what type of excersice_____
Other daily activities:_____ Occupation:_____
Primary Care Physician:_____ Chiropractor:_____
How do you relieve stress or pain?_____

What are the reasons for your visit today?
What are your other health concerns?
Describe any surgeries you have had:
Describe any accidents you have had:
List all conditions currently monitored by a Health Care Provider:
List any medications that you took today:

Please note all current and previous conditions:					
Headache	Y	N	Stiff/painful joints	Y	N
Sleep Problems	Y	N	Neck, shoulder, or arm pain or numbness	Y	N
Fatigue	Y	N	Low back, hip or leg pain or numbness	Y	N
Flu or cold symptoms in the last 48 hours	Y	N	Sciatica	Y	N
Sinus	Y	N	Depression	Y	N
Allergies to scents or lotions	Y	N	Blood clots	Y	N
Allergies, in gereral	Y	N	Stroke	Y	N
Arthritis	Y	N	Heart disease	Y	N
Osteoporosis	Y	N	High/low blood pressure	Y	N
Scoliosis	Y	N	Poor circulation	Y	N
Broken bones	Y	N	Asthma	Y	N
Disc problems	Y	N	Thyroid dysfunction	Y	N
Spasms/cramps	Y	N	Diabetes	Y	N
TMJ (jaw pain)	Y	N	Currently pregnant	Y	N
Tendonitis/bursitis	Y	N	Malignant cancer or tumors	Y	N
Spinal Problems	Y	N	Benign cancer or tumors	Y	N
Varicose Veins	Y	N			
Describe, as needed, any conditions indicated above, or other conditions that you feel may be important					