Oregon Massage & Wellness Clinic
415 17th St Suite 8
Oregon City OR 97045

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On-Site Seated Massage Health Intake Form

Name:_____Phone _____

Home Address:_____City_____State_____Zip_____

Email:_____Date of Birth:_____

All health information will be kept confidential. Oregon Massage & Wellness Clinic follows the HIPAA guidelines for healthcare information privacy. Please answer the following questions:

Are you experiencing any of the following?

Pain ☐ yes ☐no	Stress ☐ yes ☐ no	Numbness ☐ yes ☐ no
Stiffness ☐ yes ☐ no	Allergies ☐ yes ☐ no	Headaches ☐ yes ☐ no

List current medications:_____

Do you have any recent injuries or health issues?_____

Any recent falls or accidents?_____

Massage Consent: I understand that the massage I receive is provided for the purpose of relaxation or relief of muscular tension. I further understand that chair massage is not intended as a treatment for any medical or physical condition. Because massage should not be performed under certain medical conditions: I affirm that I have stated all my known medical conditions and answered all questions honestly. By signing I acknowledge that I agree to hold no liability whatsoever against the massage therapist providing the massage.

Signature:_____Date:_____

Notes: