

CLIENT INFORMATION

Portland Massage Associates
Office Address: 142 High St. Ste 535
Mailing Address: P.O. Box 7841, Portland ME 04112
info@portlandmainemassage.com, (207) 200-1240

Name: _____ Date of Birth: _____

Mailing Address: _____

Phone Numbers: _____

Email Address: _____ OK to use email? yes no

Occupation: _____

Emergency Contact Name and Phone: _____

Referred by: _____

Have you had professional massage before? yes no Date of last massage: _____

Describe any major diagnoses / conditions and chronic / ongoing pain:

List major surgeries, accidents, injuries, and hospitalizations:

List medications, including vitamins / supplements / herbs, and what they're for:

List allergies / sensitivities to nuts, oils, herbs, or scents. Please note if you are vegan.

List stress reduction activities, and frequency:

Is there anywhere you would *not* like to be touched today?

Check any of the following that apply to your current health:

<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Rashes
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Athlete's foot
<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Warts
<input type="checkbox"/> Circulatory Condition	<input type="checkbox"/> Fibromyalgia or Chronic Fatigue Syndrome
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> High/low blood pressure
<input type="checkbox"/> Cancer	<input type="checkbox"/> Spinal injury/surgery
<input type="checkbox"/> Infection	<input type="checkbox"/> Headaches
<input type="checkbox"/> Breathing difficulty	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Tendonitis

Is there anything else your massage therapist should know? Please explain.

It is my choice to receive massage therapy. I agree to communicate with my practitioner any time I feel as if my well-being is being compromised. I understand that potential risks of massage include: mild, short term muscle soreness due to movement of irritating metabolic wastes; mild surface level bruising.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal or skeletal manipulations.

I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health.

Client Signature: _____ Date: _____

CONSENT TO TREATMENT OF MINOR: I hereby authorize the above-named practitioner to administer massage/bodywork to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____