

# Melodic Movement Therapeutic Massage

Lindsay Newman LMT, OR Lic #16508 practice based in Hillsboro OR. Phone 503-724-4443

**WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions or concerns regarding your session please let me know so that I can work to support your healing experience.**

## First visit intake form – all information will be kept confidential.

Full Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Preferred Spoken Name \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

E-mail address: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact Name and Phone: \_\_\_\_\_

How did you hear about my practice? \_\_\_\_\_

Your Occupation: \_\_\_\_\_

Do you suffer from chronic or persistent pain/discomfort? \_\_\_\_\_ If so, for how long? \_\_\_\_\_ Do you know what caused it or when the symptoms seem to get worse or better? \_\_\_\_\_

Please indicate any conditions that you have had or currently have:

- |  |  |
|--|--|
| <input type="radio"/> allergies                            | <input type="radio"/> jaw pain/TMJ syndrome        |
| <input type="radio"/> advanced, acute, or chronic diseases | <input type="radio"/> arthritis                    |
| <input type="radio"/> heart/circulatory problems           | <input type="radio"/> tendonitis                   |
| <input type="radio"/> headaches/migraine                   | <input type="radio"/> diabetes                     |
| <input type="radio"/> fainting                             | <input type="radio"/> paralysis                    |
| <input type="radio"/> blood pressure issues: high / low    | <input type="radio"/> hemorrhages                  |
| <input type="radio"/> major accidents                      | <input type="radio"/> hemophilia                   |
| <input type="radio"/> surgeries                            | <input type="radio"/> fibromyalgia/chronic fatigue |
| <input type="radio"/> implants                             | <input type="radio"/> recent injuries              |
| <input type="radio"/> numbness/persistent tingles          | <input type="radio"/> Pregnancy                    |
| <input type="radio"/> cancer/ tumors                       | <input type="radio"/> Other:                       |

Please describe any conditions you have checked above: \_\_\_\_\_

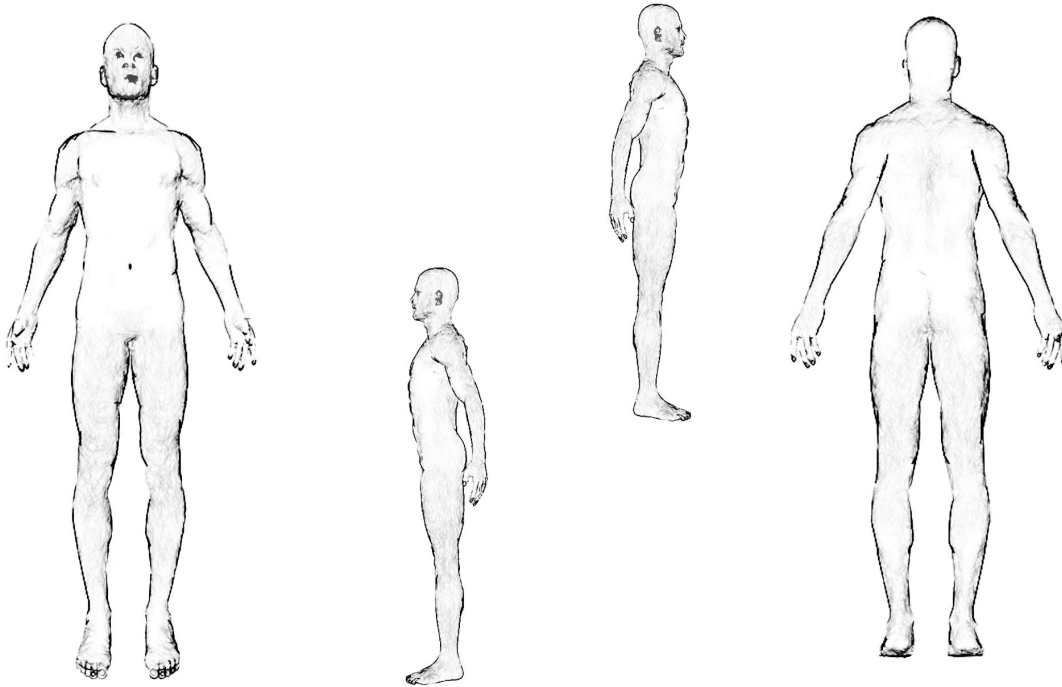
***Depending on your condition, for your safety I may need to consult with your primary care physician to tailor a plan of treatment appropriate for your body.*** Primary Care Physician's Name and Contact Info: \_\_\_\_\_

Other forms of health care you are receiving: \_\_\_\_\_

Medications you are currently taking:

Purpose of visit today: \_\_\_\_\_

**X over any specific areas you want concentrated on during your session:**



Have you ever had a professional massage before? \_\_\_\_\_

If so, how often? \_\_\_\_\_ and what type? \_\_\_\_\_

How, besides massage, do you relieve stress or pain? \_\_\_\_\_

Activities you do listing those you participate in most frequently first:

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**Informed Consent and Massage Policies:** I understand that if I experience any unusual discomfort and/or pain during my massage sessions it is my responsibility to inform the massage therapist so that she can adjust the technique or pressure being used. The massage therapist will not diagnose illness, disease, or any further physical or mental disorders nor prescribe medical treatment or pharmaceuticals, or perform spinal manipulations. Rather, the purpose of this massage is exclusively for relaxation and soft tissue care. I understand that massage is not a substitute for medical treatment or diagnosis and that it is recommended that I see a physician for any ailments that I may have.

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

