

Jade Acupuncture

Massage Intake

1920 NW Lovejoy St

Portland, OR 97209

503-417-1774

Name: _____

Address: _____

Phone: (work) _____ (home) _____ (cell) _____

Email: _____ Date of Birth: _____

Emergency Contact _____

Relationship to you: _____ Phone: _____

Were you referred by anyone? _____

Please circle any of the following that apply to you:

- | | | | |
|------------------|--------------------|----------------------|--------------------------|
| Skin Disorders | Pregnant | Communicable Disease | High/Low Blood Pressure |
| Heart Conditions | Epilepsy | Seizures | Allergies |
| Diabetic | Frequent Headaches | Varicose Veins | Cancer (current or past) |
| Nausea | Easy Bruising | Arthritis | Injuries/Accidents |
| Stroke | Gastrointestinal | Heart Disease | Compromised Immune |
| Psychological | Musculoskeletal | Surgery | Respiratory Disorder |

Please explain any of the health problems indicated above _____

Please list any medications or supplements (including herbs and supplements) you are currently taking: _____

Are you currently under the care of a physician? If so, for what? Please include their name and phone number. _____

Have you ever received massage or bodywork before? (If yes, how was it?) _____

What would you like to receive from this massage? _____

Would you like me to focus on any specific area(s)? _____

Would you like me to avoid any specific area(s)? _____

Client Consent: I attest that the above is true and accurate to the best of my knowledge. I understand I will be receiving a therapeutic massage for the purpose of maintaining good health and physical condition. Further, I understand that massage therapists may not diagnose or treat injuries/diseases and that massage should not take the place of a doctor's care when necessary. I also acknowledge the 24 hour cancellation policy; without 24 hours notice of cancellation I will pay for the missed appointment.

Signature: _____ Date: _____