



Sheila Resari, LMT #12784  
5517 N Commercial Ave, Portland, OR 97217  
Ph: 503-880-7977 Fax: 503-223-1188  
www.truenorthmassage.com

### Confidential Information

Name \_\_\_\_\_ Date of initial visit \_\_\_\_\_

Address \_\_\_\_\_

Primary Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Email \_\_\_\_\_ Opt-in to newsletter:  Yes  No

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Marital/Relationship Status \_\_\_\_\_ Referred By \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

### Reason for Visit

Primary reason for visit \_\_\_\_\_

When did you first notice it? \_\_\_\_\_ What brought it on? \_\_\_\_\_

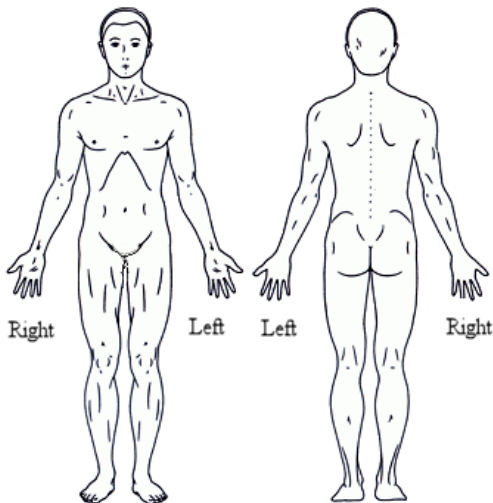
Describe any stressors occurring at the time \_\_\_\_\_

What activities provide relief? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

Is this condition getting worse? \_\_\_\_\_ Interfere with work \_\_\_ sleep \_\_\_ recreation \_\_\_

Is this visit related to a work-related injury or auto accident?  Work  Auto  Neither

Please list, in order of importance, any other reasons you are here today \_\_\_\_\_



Circle degree of discomfort: 0 none, 10 severe  
0 1 2 3 4 5 6 7 8 9 10

Mark your sensations on the picture:

Numbness = = =      Sharp/Stabbing      / / /

Dull Ache O O O      Pins, Needles      + + +

Burning X X X      Other \_\_\_\_\_      ^ ^ ^



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### Medical History

Are you under the care of another health care provider(s)? \_\_\_\_\_ Reason (s) \_\_\_\_\_

Name (s) of Practitioner \_\_\_\_\_ Phone \_\_\_\_\_

Insurance carrier \_\_\_\_\_ Plan number \_\_\_\_\_

Have you had massage before? \_\_\_\_\_ What type(s)? \_\_\_\_\_

Current Medications/Supplements \_\_\_\_\_

Any noticeable side effects? \_\_\_\_\_

Allergies/Sensitivities: specify allergen and reaction \_\_\_\_\_

Any Illness, Injury, Surgery, or Trauma in past 3 years *or* that still affects you (date, treatment, status):  
\_\_\_\_\_  
\_\_\_\_\_

#### Mark any conditions you have currently or have experienced recently (past year):

**GENERAL**

- Dizziness
- Fainting
- Headache/Migraines
- Sleep Disorder
- Fatigue

**MUSCLES & JOINTS**

- Muscle Cramps
- Swollen Joints
- Painful Joints
- Stiff Joints
- Joint Replacement
- Joint Instability
- Sore Muscles
- Weak Muscles
- Sprains/Strains
- Broken Bones
- TMJ Issues
- Disc Problems
- Scoliosis
- Arthritis
- Osteoporosis

**GENITO-URINARY**

- Kidney Infection
- Kidney Failure
- UTI
- Bladder Control Loss
- Painful Periods
- Currently Pregnant
- IUD

**NERVOUS SYSTEM**

- Numbness/Tingling
- Shooting Pain
- Sciatica
- Depression
- Anxiety
- Confusion
- Loss of Memory

**RESPIRATORY**

- Asthma
- Bronchitis
- Common Cold
- Flu

**CARDIO-VASCULAR**

- High Blood Pressure
- Low Blood Pressure
- Heart Condition
- Chest Pain
- Poor Circulation
- Strokes
- Anemia
- Edema
- Varicose Veins
- Blood Clots
- Phlebitis
- Aneurysm

**GASTRO-INTESTINAL**

- IBS
- GERD
- Hepatitis
- Constipation
- Diarrhea
- Nausea
- Abdominal Pain
- Ulcer

**SKIN OR ALLERGIES**

- Boils
- Scar Tissue
- Acne
- Bruising Easily
- Eczema/Dermatitis
- Rash
- Psoriasis
- Warts
- Fungus
- Itching
- Sensitive Skin
- Cut/Bruise/Burn
- Herpes
- Other Contagious Condition

**OTHER**

- Cancer
- Tumors
- Epilepsy
- Diabetes
- Chronic Pain

I verify that all of the information provided is correct and current to the best of my knowledge and will inform my practitioner of any changes in my health.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Massage Policies

*Please read the following statement carefully, then sign and date at the bottom.*

- I take responsibility to update any pertinent health or contact information during future visits. I take responsibility for my personal belongings.
- I understand that the therapist does not diagnose, treat, or prescribe for any illness, ailment or disease, nor do spinal adjustments. Massage is not a substitute for medical examinations and/or diagnosis, and I should see a physician if needed.
- I am aware that this is a non-sexual massage. Any misconduct or inappropriate behavior will result in immediate termination of the massage with full payment due. I understand that I will be fully covered with a sheet (known as a “drape”) at all times and only the body part being worked on will be uncovered.
- I understand that I am in control of my session and can stop at any time; I will comment on my comfort or discomfort regarding pressure, technique, or area. I understand that for my own safety and my therapist’s, it is unacceptable to receive bodywork while under the influence of alcohol or illicit drugs.
- If I running late for an appointment, I agree to call as soon as possible; I understand that my time may be shortened as a result. I understand that 24 hours notice of cancellation is required. For a late cancellation or missed appointment, I will be responsible for a **\$30 fee**.
- It is my responsibility to pay for all services provided. In the event that my insurance company denies payment or makes a partial payment, I am responsible for the balance. By paying for my session at the time of service, I qualify for a time-of-service discount.
- I acknowledge that I received this office’s Notice of Privacy Practices, which describes my privacy rights and how my health information may be used or disclosed.

- The areas I feel **comfortable** receiving massage include:

Scalp	Abdomen	Thighs	Neck
Face	Arms	Lower Legs	Back
Upper Chest	Hands	Feet	Glutes

Client Signature \_\_\_\_\_

Date \_\_\_\_\_