Colleen McClenahan
Licensed Massage Therapist, OR Lic. #7338
7409 SW Capitol Hwy, Suite 206
Portland, OR 97219

The Bodhi Tree
2161 NE Broadway
Portland, OR 97232

Confidential Health Information

PLEASE PRINT

NAME_____ DATE_____REFERRED BY: _____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE (H)_____ (W)_____ (Cell)_____

E-MAIL ADDRESS (OPTIONAL) _____

Date of Birth _____ Occupation_____

Emergency contact _____ Phone _____

Massage History/Treatment Information

Have you ever received a professional massage? Yes No Date _____

What results do you want from your massage session? _____

_____

Please circle areas of the body that you give me permission to massage:

All Back Legs Hips/Glutes Arms Abdomen Chest Neck Head Face Feet

List stress reduction techniques, exercise activities and frequency:

_____

Are you currently seeing a medical professional? Yes No If yes, please explain:

_____

Please list any medications you are currently taking (please include supplements, naturopathic remedies, and recreational drugs)

_____

Heath History

(Include year and treatment received/receiving)

Surgeries (year): _____

Broken Bones (year) : _____

Illnesses (year): _____

Musculo-skeletal & Joint

Bone or joint disease _____

Tendonitis _____

Bursitis _____

Arthritis _____

Osteoarthritis _____

Sprain/Strain_____

Disc herniation(s)/bulge(s) _____

Fibromyalgia _____

Spondylolisthesis _____

Spasms/cramps _____

Jaw Pain/TMJ_____

Osteoporosis_____

Scoliosis_____

Other _____

Circulatory

Heart condition _____

Atherosclerosis _____

Arteriosclerosis _____

Hypertension _____

Varicose veins_____

Blood clots _____

Lymphedema _____

Other_____

Infectious Disease

Disease Name(s) _____

Skin

Allergies _____

Dermatitis _____

Psoriasis _____

Athletes Foot _____

Warts_____

Other _____

Digestive

Constipation _____

Crohn's Disease _____

Hepatitis _____

Diverticulosis _____

Irritable Bowel Syndrome_____

Other _____

Nervous System

Herpes/shingles _____

(Nervous System cont.)

Parkinson's disease _____

Multiple sclerosis _____

Polio/Post polio _____

Seizures _____

Spina Bifida _____

Numbness/tingling _____

Fatigue _____

Sleep disorders _____

Lupus_____

Other _____

Reproductive

Pregnant (Trimester)_____

PMS _____

Genital Herpes/Warts _____

Other _____

Other

Cancer/Tumors_____

Diabetes_____

Eating Disorders_____

Anxiety _____

Depression _____

Bipolar Affective Disorder _____

Sinus infection _____

Asthma _____

High cholesterol _____

Headaches/migraines _____

Urinary/Bladder _____

To comply with the State of Oregon's informed consent regulation, I will inform you of the following items:

- What to expect from the entire bodywork session
- The proposed treatment plan including massage, movement therapy and hydrotherapy
- Any contraindications or precautions

Informational Statement: By my signature, I state that I understand I will receive a therapeutic massage for the purpose of maintaining good health and physical condition. I agree to communicate with my therapist any time I feel that my well-being is being compromised. I understand that the therapist is not legally permitted to diagnose or treat injuries or diseases, and that massage should not take the place of a doctor's care when indicated. I also understand that I or the therapist may change the treatment plan should I experience any pain or discomfort with the massage. The therapist is not permitted to disclose or release any information regarding the client's personal information or treatment session without the written consent of the client. I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

_____ _____

Client Signature Date