Colleen McClenahan
Licensed Massage Therapist, OR Lic. #7338

7409 SW Capitol Hwy, Suite 206
Portland, OR 97219

2808 NE MLK Jr. Blvd, Ste C.
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 _______________________

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