Kurt Marion, L.M.T. OR LIC # 9444
4829 NE MLK Jr. Blvd.
Portland, OR 97211-3351
(503) 283-8133

Massage Health History

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Best Phone Number to get a hold of you: _____ (circle) CELL WORK OTHER

DOB: _____ Occupation: _____

1. What brings you in for a massage today? _____

_____

2. Have you had a massage before? YES ( ) NO ( ) If yes date of last massage? _____

3. Please mark with an "X" any and all conditions you have experienced or are experiencing now.

( ) Migraines or consistent headaches
( ) Vision problems, contact lenses
( ) Head injury
( ) Sinus problems
( ) Jaw pain or TMJ issues
( ) Asthma or Lung problems
( ) Abdominal or digestive problems
( ) Diabetes
( ) Blood Clotting problems
( ) Chronic pain
( ) Muscle or joint pain
( ) Broken bones
( ) Numbness or tingling
( ) Sprains or strains
( ) Arthritis, Tendonitis
( ) Cancer or tumors
( ) Heart or circulatory problems
( ) Varicose veins
( ) Fatigue
( ) Tension or stress
( ) Sleep difficulties
( ) Allergies
( ) Dislocations
( ) Skin rashes, athlete's foot
( ) Infectious diseases
( ) Pacemaker
( ) Any other medical condition NOT listed

4. Do you have High Blood Pressure? YES ( ) NO ( )

5. Explain any areas noted above and whether you are currently seeing a doctor: _____

_____

_____

6. Current medications (including common nonprescription medications): _____

_____

7. Have you had any surgeries in the last 5 years? _____

_____

8. Any factors contributing to stress? _____

_____

_____

9. Please list primary sport(s): _____

_____

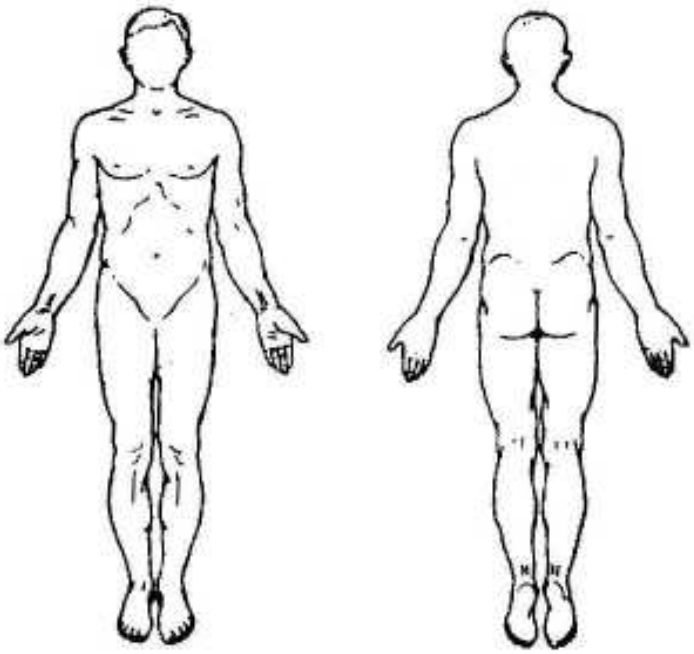
10. Please list all forms and frequency of stress-reducing activities (hobbies, yoga, etc.): _____

_____

_____

Pain and Discomfort Chart

Please mark problematic areas on our friendly “Body Map”.
Mark (+) for Pain/sore areas
(0) for areas you feel are tight
(*) for areas of numbness, tingling, “altered sensations”



WAIVER:
I have stated to the best of my ability, all medical conditions that I am aware of, and I will inform the Massage Practitioner of any changes to my health status as indicated above. I agree to immediately inform the therapist if I experience any pain or discomfort during the massage treatment so that the pressure and/or strokes may be adjusted to my level of comfort. I assume all risks and responsibilities from any injury or liability that may occur as a result of this session and any future sessions.

DATE: _____ Printed Name: _____

Signature: _____ Guardian signature if UNDER 18: _____

Therapist Signature: _____