CASCADE orthopedic MASSAGE

☐ 18750 Willamette Dr. Ste F
West Linn, OR 97068

☐ 5231 NE Martin Luther King Jr. Blvd
Portland, OR 97211

Information & Consent Form

Name:_____ Home phone:_____

Address:_____ City/State/Zip:_____

Cell phone:_____ Work phone:_____ DOB:____/____/_____

Email:_____ (we don't share email) How did you hear about us?_____

Occupation:_____ Employer:_____

Emergency contact:_____ Phone number:_____

Insurance Company:_____ ID #:_____ Group #_____

What is the reason for today's visit?_____

Were you recently involved in an auto accident?_____ Were you recently injured at work?_____

Insurance Company:_____ PIP/Worker's Comp. claim #:_____

Have you ever had a professional massage or bodywork before?_____ When?_____

Women only - Are you pregnant or trying to get pregnant?_____
If yes, how far along are you?_____

PLEASE MARK IF YOU HAVE / HAD ANY OF THE FOLLOWING CONDITIONS

__Heart Conditions
__High Blood Pressure
__Vascular/Blood Disorders
__Diabetes
__Cancer
__Respiratory Disorders
__Arthritis
__Osteoporosis
__TMJ Syndrome
__Broken Bones
__Headaches
__Migraines
__Back or Chest Aches
__Sciatic Pain
__Leg/Foot Pain
__Herniated/Bulging/Degenerative Discs
__Neuropathies
__Edema
__Breast Augmentation
__Dentures
__Wear Contacts
__Allergies (Hay fever, Animals, etc.)
__Allergies to oils/scents If yes, which ones?_____
__Radiation/Chemotherapy Treatment If yes, when?_____

CASCADE orthopedic MASSAGE

☐ 18750 Willamette Dr. Ste F
West Linn, OR 97068

☐ 5231 NE Martin Luther King Jr. Blvd
Portland, OR 97211

Do you smoke?_____ Drink alcohol?_____ Drink caffeine?_____
Drink lots of soda (diet or regular)?_____ Use lots of salt?_____
Do you have any exercise or stretching habits?_____
If yes, how many times per week / duration?_____
Please advise us of any other health care professionals you have seen for this condition:_____
_____

Do you take any prescription medication?_____ If yes, please list: _____
_____

Do you have any other medical issues including surgery that we should be aware of before giving you massage therapy?_____ If yes, please describe:_____
_____

Please read the following, initial and sign below:

_____I understand that massage therapy is given for the treatment of, but not limited to: 1) The fulfilling a prescription of a treating physician, or other authorized health care provider, for a medically necessary condition, 2) For relief from muscular tension and imbalance, spasm, or increasing circulation and energy flow. I understand that the massage therapists do not diagnose illness, disease, or any other physical or mental disorder. Massage therapy is not a substitute for medical examinations and/or diagnosis. It is recommended that I see a physician for any physical ailment that I might have.

_____Because the massage therapist must be aware of existing physical conditions, I have stated all of my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

_____I will respect the time of the massage therapist and other clients. I agree to come to my scheduled appointments promptly, barring any unforeseen emergency. I understand that if I cancel later than 4 hours prior to my appointment, I will be required to pay HALF the cost of my appointment. If I NO SHOW, I have to pay the full price of the appointment.

_____I understand that by providing my insurance information, I am authorizing Cascade Orthopedic Massage to bill my insurance company on my behalf and receive payment from the insurance company for serviced received. I also understand that I am financially liable for payment to Cascade Orthopedic Massage for services received in the case that my insurance company denies payment for any reason.

Client Signature:_____ Date:_____

* * *

AUTHORIZATION TO TREAT A MINOR (PLEASE ONLY SIGN IF PATIENT/CLIENT IS A MINOR):
As a parent or legal guardian, I hereby authorize treatment of massage therapy.

Parent/Guardian Signature:_____ Date:_____