

- 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 #: \_\_\_\_\_

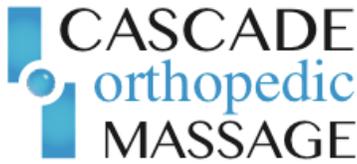
Have you ever had a professional massage or bodywork before? \_\_\_\_\_ When? \_\_\_\_\_

**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**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Heart Conditions                 | <input type="checkbox"/> TMJ Syndrome                         |   |
| <input type="checkbox"/> High Blood Pressure              | <input type="checkbox"/> Broken Bones                         | <input type="checkbox"/> Neuropathies                         |
| <input type="checkbox"/> Vascular/Blood Disorders         | <input type="checkbox"/> Headaches                            | <input type="checkbox"/> Edema                                |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Migraines                            | <input type="checkbox"/> Breast Augmentation                  |
| <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Back or Chest Aches                  | <input type="checkbox"/> Dentures                             |
| <input type="checkbox"/> Respiratory Disorders            | <input type="checkbox"/> Sciatic Pain                         | <input type="checkbox"/> Wear Contacts                        |
| <input type="checkbox"/> Arthritis                        | <input type="checkbox"/> Leg/Foot Pain                        | <input type="checkbox"/> Allergies (Hay fever, Animals, etc.) |
| <input type="checkbox"/> Osteoporosis                     | <input type="checkbox"/> Herniated/Bulging/Degenerative Discs |   |
| <input type="checkbox"/> Allergies to oils/scents         | If yes, which ones? _____                                     |   |
| <input type="checkbox"/> Radiation/Chemotherapy Treatment | If yes, when? _____   |   |



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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: \_\_\_\_\_