

**MILWAUKIE WELLNESS CENTER
CONFIDENTIAL MASSAGE INTAKE FORM**

PLEASE PRINT CLEARLY

Name _____ Mid. _____ Last _____

Address _____ City _____

State _____ Zip _____ Birthdate _____

Work Phone _____ Home Phone _____ Cell _____

Emergency Contact _____ Phone _____

Would you like to be included on our email list? E-mail Address: _____

Briefly describe your reasons for coming in today _____

Are you currently under a physician's care? YES / NO If yes please specify reason and with whom:

PLEASE LIST YOUR COMPLETE MEDICAL HISTORY INCLUDING:

Fractures/Dislocations _____ When _____

Surgeries _____ When _____

Cancer _____ When _____

Recent Accidents, Injuries or Illness _____

Other _____

Are You Taking Any Medications? YES/NO If so, what kind? _____

PLEASE CIRCLE ANY OF THE FOLLOWING IF YOU HAVE HAD ANY OF THESE CONDITIONS:

Heart Disease	PMS/Painful Menses	Contagious Disease	Hypertension	Skin Rash
Abcess	Phlebitis	Allergies	Fever	Herpes
Headaches	Epilepsy	Easy Bruising	Osteoporosis	Arthritis
HIV+/AIDS	Diabetes	High Blood Pressure	Pregnancy	Contact Lenses
Infection	Atherosclerosis	Other _____		

Is there any area you would like extra time spent? _____

Do you have a preference for a specific type of massage? _____

Signature _____ Date _____

Therapists Notes _____