Courtney Truax, LMT
Because every body needs a break

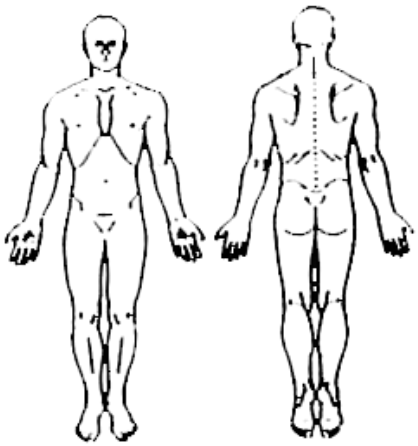
Client Health Intake Form

***Name:**_____ ***Date:**_____
***Address:**_____
_____
Phone:**_____Email:**_____ **OK to send emails? Y/N**
Occupation:_____ ***Date of Birth:**_____
How Heard/Referred by:_____
Have you had a professional massage before?_____
When was your last massage?_____
Emergency Contact:_____ **Phone:**_____
Health Care Provider (Doctor)_____**Phone:**_____

PLEASE CHECK IF YOU HAVE, OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

___ **Skin conditions (Acne, rash, skin cancer, other)**
___ **Lymphatic condition (Swollen glands, Lymphoma, Lymph edema, other)**
___ **Recent Injuries (Whiplash, sprain, deep bruise, other)**
___ **Recent knee or hip injury**
___ **Recent injections at a joint or muscle junctures (Cortisone, Botox)**
___ **Recent eye surgery (Lasik in the past 72 hours)**
___ **Circulatory condition (Heart disease, high blood pressure, varicose veins, arrhythmia, Thrombosis, arteriosclerosis, pacemaker, stint, or shunt)**
___ **Boils or Abscesses**
___ **Diabetes**
___ **Low blood sugar**
___ **Aneurysm**
___ **Irritable bowel syndrome**
___ **Kidney disorder**
___ **Joint stiffness or joint pain**
___ **Tendency for headaches**
___ **Dislocation of shoulder**
___ **Pregnancy or trying to get pregnant**
___ **Heavy or unusual menstrual flow**
___ **Breast or any other implants within the last year**
___ **Bone conditions (osteoporosis, rib fractures, cancer, or other)**
___ **Neurological conditions (sciatica, numbness/tingling, stroke, or epilepsy)**
___ **Emotional difficulties (depression, anxiety, other)**
___ **Previous surgeries (please state date and type):**_____

**** Please circle areas of pain:**



Do you have any allergies? If yes, please list:_____

Are you taking any of the following medications?
Coumadin___ Lavonox___ Heparin___ Heavy Aspirin___ Other___

I give you my permission to contact my health care provider should the need arise.

***Client Signature:**_____ **Date:**_____

Client Disclaimer:

This letter is to express and explain that you are receiving a deep tissue technique. Although some clients ask for deeper compression, I prefer to keep the compression at a therapeutic level that I feel comfortable with. Your comfort is my number one concern!

Due to the serious nature of this technique, I would appreciate that you understand that should you experience pain, stiffness, soreness, skin irritations, marks, headaches, sinus congestion, bruises or any injury or condition, that you do not hold Courtney Truax, LMT liable. In addition, if you request for more compression on a higher level than that of the therapeutic range I am delivering, I will not be held responsible for aggravating a condition that may already be present.

*Client Signature_____ *Date_____

*Client Name (Printed) _____

COVID-19 Addendum:

***Client Information:**

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐

2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes ☐ No ☐

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ☐ No ☐

Consent for Treatment:

I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

*Client Signature: _____ *Date: _____

*Client Name (Printed)_____

Thank you,
Courtney Truax, LMT #17592
460 5th St, Ste. E
Lake Oswego, OR 97034