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##### Brief Massage History Questionnaire

*Please complete this brief questionnaire so that I may better understand your history regarding massage. If patient is a minor, please have legal guardian complete and sign. This will enable the massage to be more effective.* ***All information is kept in strict confidence. Thank you.***

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ C W H

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_

email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did you hear about me? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact and phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Have you had a professional massage before?

Y N Are you taking any drugs or medications? (If yes, explain here.)

Y N Are you currently under the care of a health care practitioner?

Health Care Practitioner Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_ C W H

Reason for Tx ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­

Y N Do you have an area or areas of the body that need special attention? (Where?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Regions of your body that you do not want massaged? (Where?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What, if anything, makes your symptoms better?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_

What, if anything, makes your symptoms worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your goals for your massage session today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Have you experienced any of the following? (one check if ever experienced, two checks if currently an issue)***

\_\_\_\_\_\_ circulation problems \_\_\_\_\_\_ broken bones (recent?) \_\_\_\_\_\_ pregnancy # \_\_\_\_\_ live birth(s) #

\_\_\_\_\_\_ heart disease \_\_\_\_\_\_ osteoporosis \_\_\_\_\_\_ anxiety

\_\_\_\_\_\_ high (or low) BP \_\_\_\_\_\_ skin allergies/ sensitivities \_\_\_\_\_\_ history of abuse

\_\_\_\_\_\_ varicose veins \_\_\_\_\_\_ recent illness/injury \_\_\_\_\_\_ depression

\_\_\_\_\_\_ lack of feeling in parts of body (Where?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_contagious disease(s) \_\_\_\_\_\_ mental/emotional diagnosis

\_\_\_\_\_\_ joint swelling/inflammation \_\_\_\_\_\_ migraines \_\_\_\_\_\_ trouble sleeping

\_\_\_\_\_\_ open cuts/sores \_\_\_\_\_\_ headaches \_\_\_\_\_\_ cancer

\_\_\_\_\_\_ diabetes \_\_\_\_\_\_ arthritis \_\_\_\_\_\_ chemotherapy

\_\_\_\_\_\_ seizures \_\_\_\_\_ lymph node removal \_\_\_\_\_­­\_ radiation

\_\_\_\_\_\_ other

***The purpose of massage is to maintain good health and physical condition. I understand that LMT’s may not diagnose or treat disease and that massage should not take the place of a doctor’s care. Either the LMT or the patient may terminate the session should either be experiencing discomfort during the massage. Discomfort may include (but is not limited to) physical pain, sexually suggestive behavior or personal remarks or requests. Payment is due at the time of the appointment and 24 hournotice is required to avoid a no show fee / payment for a missed session. My initials signify that I understand and agree to abide by these policies and procedures.***

***Initial here \_\_\_\_\_\_\_\_\_\_***