true health MEDICINE PC

Tualatin Clinic address:
8555 SW Tualatin Road
Suite B
Tualatin, OR 97062
Phone: (503) 691-0901

Scappoose Clinic address:
51669 SW Columbia River Hwy
Suite 130
Scappoose, OR 97056

Mailing address:
PO Box 909
Tualatin, OR 97062
Fax: (503)691-9018
www.TrueHealthMedicine.com

PERSONAL INFORMATION

Name: _____ Date: _____

Address: _____

City/State/Zip: _____

Telephone# (home): _____ (cell): _____ (work): _____

Is there any reason we cannot send mail with our clinic name and return address on the envelope to your home? Y N
Is there any reason we cannot leave a voicemail message for you on any of your phone numbers? Y N

Email address: _____

Age: _____ Date of Birth: _____ Gender: _____

Please circle: Married Separated Divorced Widowed Single Partnership

Live with: Spouse Parents Children Friends Alone Other:_____

Occupation: _____ Hours per week: _____

Employer: _____ Phone: _____

How did you hear about our clinic? _____

Has any other family member already been a patient at the clinic? _____

INSURANCE

Insurance Co: _____

Primary Insured Name: _____Phone: _____

Primary Insured Address: _____

Policy/ID Number: _____ Group Number: _____

Is your insurance through (circle one): Employer Cover Oregon Other: _____

Do you have Secondary Insurance? Y N Please bring in all applicable insurance cards to every visit..

EMERGENCY CONTACT

Emergency Contact: _____

Relationship: _____ Phone: _____

HEALTHCARE PROVIDERS

Are you currently established with a primary care provider (PCP)? If yes, please provide their contact information. Please list any other healthcare providers you would like us to coordinate care with.

_____

_____

_____

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Informed Consent for Massage Therapy

I hereby request and consent to the performance of massage therapy by the licensed massage therapist(s) employed by or contracted with True Health Medicine, PC. Massage in general provides benefits of stress reduction, relief from muscular tension, spasm, or pain, and it increases circulation and energy flow. I understand that massage therapists do not diagnose illness or disease, perform any spinal manipulations, nor do they prescribe any medical treatments. I am aware that therapeutic massage is not a substitute for medical examination and I will seek health care for those services. I accept that massage promises no long-term results nor will it cure my health problems.

I acknowledge my understanding and agreement with the following:

● The therapist must be aware of all health conditions due to certain contraindications or cautions for massage. I have disclosed all such conditions. I will also update any changes to my health in future sessions. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information about my health or condition.

● If at any time during the massage the client or therapist is uncomfortable for any reason, they shall immediately say so. If you feel uncomfortable for any reason, you have the right to request an immediate stop to the session or request a modification to the treatment, regardless of prior consent given.

● Treatment with therapeutic massage may be relaxing, but may also occasionally create pain or discomfort. Please provide feedback as to pressure (deeper or lighter) and discuss painful or ticklish areas of your body.

● Privacy will be assured as you have the right to dress down only to your comfort level and according to the requirements of your treatment. Draping will be used by the therapist as required to expose only those parts of your body that require treatment and/or as you choose to ensure comfort during the treatment.

● Sexual advances of any kind will not be tolerated. Any illicit or sexually suggested remarks or advances will result in immediate termination of the treatment.

True Health Medicine, PC office and privacy policies apply to massage therapy. In particular, please recall:

● Children are not permitted in the massage room and must have childcare provided for them during the massage.
● Please turn off or silence cell phones and pagers prior to your treatment.
● Please refrain from wearing fragrances to the office.

Your signature below means that:

a. You understand the information provided on this form and agree to the foregoing.
b. The procedure(s) set forth above has been adequately explained to you by your massage therapist and questions have been answered to your satisfaction.
c. You have received all the information and explanation you desire concerning the procedure.
d. You authorize and consent to the performance of the procedure(s).

Patient Name: _____ Date of Birth: _____

Signature: _____ Date:_____

If signed by someone other than patient, please indicate relationship:

_____

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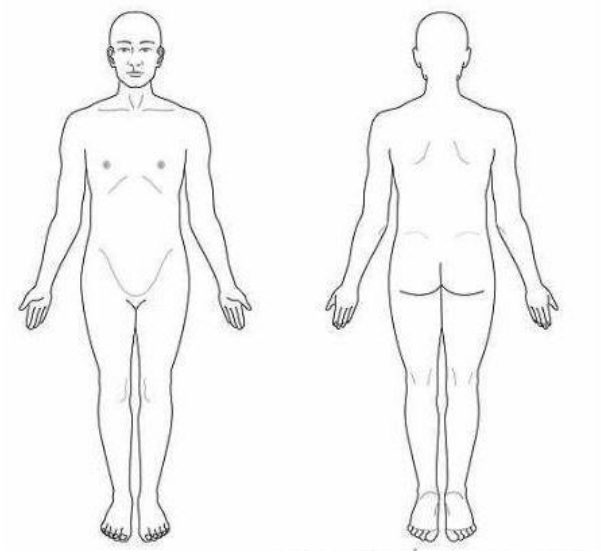
Massage History Form

Patient Name: _____ Date of Birth: _____

CHIEF COMPLAINT
Please list the issues you would like to address with massage therapy and indicate any areas of pain, tension or discomfort on the pictures.



_____

_____

_____

_____

_____

_____

Is your injury or chief complaint the result of a car or work related accident? Y N
If so, please explain:

_____

Are you currently under the care of a physician (other than those at this clinic)? Y N
If so, please provide their name and phone number:

_____

HEALTH HISTORY Please mark the circle for all that apply to you.

- ◯ Pregnant or trying to conceive
- ◯ Wear contact lenses
- ◯ Wear dentures
- ◯ Wear hearing aids
- ◯ Surgical implants
- ◯ Recent caffeine use
- ◯ Recent drug or alcohol use
- ◯ Are you feeling ill today?
- ◯ Recent injury or illness
- ◯ Long term injury or illness
- ◯ Circulatory problems, varicose veins
- ◯ Heart disease
- ◯ Asthma, COPD, Shortness of breath
- ◯ Area of sensory abnormality
- ◯ Peripheral neuropathy
- ◯ Open cuts or sores
- ◯ High or low blood pressure
- ◯ Skin disease
- ◯ Osteoporosis
- ◯ Cancer
- ◯ Diabetes
- ◯ Seizures
- ◯ Arthritis
- ◯ Bruise easily
- ◯ Allergies
- ◯ Dizziness

Do you have any difficulty lying on your front, back or side? Y N
If so, please explain:

_____

Do you have any allergy or sensitivity to oils, lotions or ointments? Y N
If so, please explain:

_____

MASSAGE HISTORY
Have you ever had a professional massage? Y N
What works best for you? _____ _____

Signature: _____ Date: _____

If signed by someone other than patient, please indicate relationship: _____