Leah Bowder, LMT
5440 SW Westgate Dr. Ste. 100
Portland, OR 97221

Health Information

Patient Name _____ Date _____
Date of Injury _____ ID #/DOB _____

Patient Information:
Address _____ City/State/Zip _____
Phone _____ Email Address _____
Occupation _____
Emergency Contact _____ Phone _____

Primary Health Care Provider:
Name _____ Phone _____ Fax _____
Address _____ City/State/Zip _____
I give my LMT permission to consult with my health care providers regarding my health and treatment.
Comments _____ Initials _____ Date _____

List Daily Activities Limited by Condition:
Work _____
Home/Family _____
Sleep/Self-care _____
Social/Recreational _____

List Self-Care Routines:
How do you reduce stress? _____
Pain? _____
List current medications (include pain relievers and herbal remedies) _____
_____
Have you ever received massage therapy before? _____ Frequency? _____
What are your goals for receiving massage therapy? _____
_____

Health History:
List and Explain. Include dates and treatments received.
Surgeries _____
_____
Injuries _____
_____
Major Illnesses _____
_____

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Check All Current and Previous Conditions

General

current past

- ☐ ☐ headaches
- ☐ ☐ pain
- ☐ ☐ sleep disturbances
- ☐ ☐ fatigue
- ☐ ☐ infections
- ☐ ☐ fever
- ☐ ☐ sinus
- ☐ ☐ allergies

Skin Conditions

current past

- ☐ ☐ rashes
- ☐ ☐ athlete's foot, warts
- ☐ ☐ other

Muscles and Joints

current past

- ☐ ☐ rheumatoid arthritis
- ☐ ☐ osteoarthritis
- ☐ ☐ osteoporosis
- ☐ ☐ scoliosis
- ☐ ☐ broken bones
- ☐ ☐ spinal problems
- ☐ ☐ disk problems
- ☐ ☐ lupus
- ☐ ☐ TMJ, jaw pain
- ☐ ☐ spasms, cramps
- ☐ ☐ sprains, strains
- ☐ ☐ tendonitis, bursitis
- ☐ ☐ stiff or painful joints
- ☐ ☐ weak or sore muscles
- ☐ ☐ neck, shoulder, arm pain
- ☐ ☐ low back, hip, leg pain
- ☐ ☐ other

Nervous System

current past

- ☐ ☐ head injuries, concussions
- ☐ ☐ dizziness, ringing in ears
- ☐ ☐ memory loss, confusion
- ☐ ☐ numbness, tingling
- ☐ ☐ sciatica, shooting pain
- ☐ ☐ chronic pain
- ☐ ☐ depression
- ☐ ☐ other

Endocrine System

current past

- ☐ ☐ thyroid
- ☐ ☐ diabetes

Cancer/Tumors

current past

- ☐ ☐ benign
- ☐ ☐ malignant

Habits

current past

- ☐ ☐ tobacco
- ☐ ☐ alcohol
- ☐ ☐ drugs
- ☐ ☐ coffee, soda

Respiratory, Cardiovascular

current past

- ☐ ☐ heart disease
- ☐ ☐ blood clots
- ☐ ☐ stroke
- ☐ ☐ lymph edema
- ☐ ☐ high, low blood pressure
- ☐ ☐ irregular heart beat
- ☐ ☐ poor circulation
- ☐ ☐ swollen ankles
- ☐ ☐ varicose veins
- ☐ ☐ chest pain
- ☐ ☐ asthma

Digestive/Elimination System

current past

- ☐ ☐ bowel problems
- ☐ ☐ gas, bloating
- ☐ ☐ bladder/kidney/prostate
- ☐ ☐ abdominal pain
- ☐ ☐ other

Reproductive System

current past

- ☐ ☐ pregnancy
- ☐ ☐ painful, emotional menses
- ☐ ☐ fibrotic cysts

It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature _____ Date _____