Dawn E. Larned, LMT #20637
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Portland, OR 97211
512.968.7577

BREATH+GRAVITY : INITIAL INTAKE

Client Name (please print) _____ **Date** _____

Client Information

Address _____

City _____ State_____ Zip _____

Occupation _____ Date of Birth _____

Telephone (day) _____ Telephone (evening) _____

Emergency Contact _____ Telephone _____

General Health Information

What are your typical daily activities – work, home, exercise?_____

_____

What substances are you currently taking? (prescribed medications, over the counter medications, herbs, supplements, alcohol, recreational drugs) _____

Are you currently under a physicians care?_____ What for?_____

What do you currently do to relieve stress?_____

_____

Have you ever received massage before? _____ When? _____

Why? _____

What was the outcome? _____

What are your current goals for massage? _____

_____

Current Health Concerns

Concerns/Issues to be addressed and brief description:_____

_____ _____

_____ _____

_____ _____

Severity	☐ mild	☐ moderate	☐ severe
Frequency		☐ constant	☐ intermittent
Symptoms		☐ increase with activity	☐ decrease with activity
Changes	☐ worse	☐ better	☐ no change

Treatment Received _____

Medications _____

Activities Limited by Condition _____

Areas of body to be avoided: _____

Do you have specific likes and/or dislikes regarding massage? _____

List any contagious conditions: _____

Please Initial:_____

dawn@breathandgravity.com

Health History Please provide information including type, approximate dates and treatment.

Surgeries _____

_____

Major Illnesses _____

_____

Injuries _____

_____

Health Conditions Circle any **current** and **previous** conditions. **Please note whether that condition is past or current**.

General			**Comments**
Pain	Numbness	Altered Sensation	_____
Headaches	Fatigue	Sleep Disturbances	_____
Infections	Swelling	Allergies	_____
Skin Conditions			
Abrasions/Cuts	Rashes	Other	_____
Muscles and Joints			
Arthritis	Osteoporosis	Scoliosis	_____
Fractures	Sprains	Strains	_____
Bursitis	Tendonitis	Stiffness	_____
Disk Problems	TMJ	Other	_____
Cardiovascular and Respiratory			
Anemia	Angina	Arteriosclerosis	_____
Heart Attack	Asthma	Congestive Heart Failure	_____
Heart Disease	Hypertension	Irregular Heart Beat	_____
Varicose Veins	Blood Clots	Phlebitis Other	_____
Nervous System			
Concussion	Head Injury	Stroke	_____
Anxiety	Depression	Other	_____
Endocrine System			
Type I Diabetes	Type 2 Diabetes	Thyroid Other	_____
Digestion and Elimination			
Heartburn	Gastric Reflux	Ulcers Other	_____
Bowel Problems	Gas/Bloating	Urinary Tract Problems	_____
Reproductive System			
Pregnancy	PMS	Other	_____
Cancer or Tumors			
Benign	Malignant		_____

Consent to Treatment: It is my choice to receive massage and/or movement therapy from Dawn E. Larned, LMT #20637. I am aware of the benefits and risks of massage and movement therapy and give my consent for these treatments. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature _____ Date _____