David Weitzer OR Lic. # 4118
Janice Weitzer OR Lic. # 4119

Licensed Massage Therapists
Traditional Thailand Massage

Name: Date:

Address: Date of Birth:

City: State: Zip:

Home Number: Work Number:

Occupation: Referred By:

Emergency Contact: Phone Number:

Is this your first professional massage? Do you wear contact lenses?

PLEASE COMMENT ON ANY OF THE FOLLOWING THAT APPLY TO YOUR HEALTH

Are you receiving medical or chiropractic treatment?

If yes, please explain:

Physician: Phone Number:

Surgeries:

Injuries:

Chronic or major illness:

Current medication(s):

Do you have chronic pain? Where?

Stress factors in your life:

Where in your body do you feel the effects of stress:

What do you do for relaxation/exercise?

CONFIDENTIAL MEDICAL HISTORY AND CONTRAINDICATIONS

Please circle any of the following conditions you are currently experiencing:

Pregnancy	Flu or Cold	Infection
Inflammation	Fever	Contagious Disease

Skin Conditions:

Cancer or undiagnosed growths

Compromised immune system:	Allergies	Anemia	HIV	AIDS
Contagious skin diseases:	Rash	Sores	Infection	
Skin sensitivity/irritability:	Bruises	Scars	Edema	Lack of sensation

Explain:

(Please turn over and complete side two)

Cardiovascular Conditions:

General:	Diabetes	Constipation (chronic or mild)
	Tire easily	Kidney problems
Circulatory:	High blood pressure	Varicose veins
	History of blood clots	Phlebitis
Cardiac:	Heart disease	Pacemaker
Respiratory:	Emphysema	Asthma
	Bronchitis	Shortness of breath

Explain: _____

Orthopedic Conditions:

Osteoporosis Osteoarthritis Rheumatoid arthritis
Musculoskeletal pain, stiffness, or stress
Any joint, neck, back injuries, or fractures

Explain: _____

Neurological Conditions:

Multiple sclerosis Parkinsons Cerebral palsy Head injury
Epilepsy Stroke Headaches Inner ear disturbances
Emotional loss: Death Disability Trauma Stress Depression

Explain: _____

Have you been Vaccinated for COVID 19 Yes ( ) No ( )

I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for those services.

I also agree that massage therapy treatments are my personal financial responsibility and that I am to pay for those services at the time of treatment unless other written arrangements have been made, and that I must change or cancel appointments with at least 24 hours notice or I will be charged the full price of my massage.

Signed: _____ Date: _____

Please fill out this form and fax to the number below before your first session. If you don't have access to a fax machine, please bring form with you to your first session.

Fax Number: 503-590-2444

You can also send this form by email to: jmweitzer@yahoo.com