Terri Anderson LMT
655 W Burnside Ste. 1
Gresham, Or 97030
(503) 348-4794

First Name: _____ Last Name: _____

Home Phone: _____ Cell Phone: _____

Date of Birth (MMDDCCYY): _____ Occupation: _____

Referred By: _____ Primary Care Physician: _____

Date of last Physical Exam (MMDDCCYY): _____

Please answer all questions and fill in the comments.

If this is not your first visit you may skip the next two sections.

1) **Have you ever had a massage by a massage therapist?** **Y____** **N____**
2) **Do you have a primary care giver (MD, DO, DC)?** **Y____** **N____**
3) **Do you have any recent injury or Illness?** **Y____** **N____**
    a. **If you answer yes to #3 please describe:**

    _____

    _____
4) **Do you have any skin eruption or irritations?** **Y____** **N____**
5) **Are you allergic to anything?** **Y____** **N____**
    a. **If yes, what?**

    _____

    _____
6) **Are you on any medications** **Y____** **N____**
    a. **If yes, why?**

    _____

    _____
7) **Do you wear contact lenses?** **Y____** **N____**

Do you have or have you ever had any of the following:

__Aids	**__Cancer**	**__Herniated Disk**	**__Scoliosis**
__Arthritis	**__Chronic Pain**	**__Hyper Tension**	**__Stroke**
__Bad Posture	**__Diabetes**	**__MS**	**__Tendonitis**
__Blood Clots	**__Fever**	**__ Pain in the Abdomen**	**__Varicose Veins**
__Bruise easily	**__Heart Disease**	**__Polio**	**__Others**
__Bursitis	**__Hernia**	**__Sciatica**	

Comments:

(Any concerns I should know about, as well as any effects from the last massage that you had.)