Good Health Naturally PLLC
Wellness Center

Relief Today,
Better Health Tomorrow

Dr. Mark J. Blessley, NTS, BS, DC
Sarah Strohmeyer, LMT

204 E. S25th Street
Vancouver, WA 98663
(360) 693-7781
www.ghn4you.com
ghn@healthonline.us

PLEASE FILL OUT COMPLETELY PRIOR TO YOUR MASSAGE (please complete both sides)

Patient Name Last-First-Middle			Date of Birth: Month / Date / Year
Address	City	State	Zip Code
Home Phone	Cell Phone	Occupation	
Emergency Contact Name & Phone Number			
Do you have any allergies to oils, lotions or odors? Do you have sensitive skin or skin conditions?			
Referring Physician	Primary Care Physician		
If an injury, was it the result of an accident? If yes: Job Related Y / N Auto Y / N Sports Y / N Other Y / N Details about the accident: _____			
Have you ever received massage therapy? Yes No When? _____/____ /_____	Type of massage experienced . Swedish, Shiatsu, Deep Tissue, Sports, Other	Pressure you prefer Light Moderate Deep	

I understand that the massage I receive is provided for the purpose of relaxation, stress reduction, relief of muscular tension and/or to correct a specific neuromuscular imbalance. If I experience pain during my session, I will inform the practitioner so that the work can be adjusted to my level of comfort.

I further understand that massage/bodywork is not a substitute for medical examination, diagnosis or medical treatment and that I should see a Chiropractor or other qualified doctor/physician or medical specialist for any mental or physical ailment that is beyond the scope of practice of a massage therapist.

I affirm that I have stated all my known medical conditions and I agree to keep the practitioner updated as to any changes in my medical profile. I understand that there shall be no liability on the practitioner's part should I neglect to do so.

Note: Our therapists strive to be on time for your massage and we ask you to do the same. They often have to drive in from their homes to be at the clinic for your massage. PLEASE give as much advance notice as you can if you will not be able to be at the clinic on time for your massage. We do reserve the right to charge you a fee for "no-shows" and/or missed appointments.

The therapists and staff at Good Health Naturally Thank you for your consideration! Enjoy your Massage!

Signature_____ Date_____ /_____ /_____

Good Health Naturally PLLC
Wellness Center

Relief Today,
Better Health Tomorrow

Dr. Mark J. Blessley, NTS, BS, DC
Sarah Strohmeyer, LMT

204 E. 25th Street
Vancouver, WA 98663
(360) 693-7781
www.ghn4you.com
ghn@healthonline.us

Check or comment on all of the following that apply to your present health:

Current Problem Area(s) _____

Allergies ___ Arthritis ___ Diabetes ___ Blood Clots ___ Blood Pressure (High or Low) ____ Broken/

Dislocated Bones ___ Bruise Easily ___ Cancer ___ Chronic Pain ___ Shoulder pain ____

Hepatitis A __B __ C __ Skin Conditions ___ Stroke ___ Surgeries _____ TMJ Disorder ___

Depression ____ Panic Disorder or other Psychological Conditions ___ Diverticulitis ___ Headaches ___

Heart Conditions ___ Disc Herniation (or fusions) ___ Heart Disease ___ Insomnia ___ Knee pain ___

Numbness/Tingling ___ Muscle Strain/Sprain ___ Scoliosis ___ Seizures ___ Tendonitis ___

Varicose Veins ___ Whiplash ___ Dizziness or vertigo ___ Joint replacement(s) ___ where? _____

Women: Pregnancy/due date ____/____ /____ Painful Menstruation ____ Endometriosis ____ Other ____

Men: Prostrate problems ____ Other _____

List physical activities you participate in regularly? _____

What movements are limited? _____

List previous injuries or surgeries _____ _____

Describe the events of any recent injury or accident: _____ _____

_____

What other treatments are you receiving? (Acupuncture, Physical Therapy, Chiropractic, Naturopathic, other)

Are you seeing any specialist(s)? _____

What therapies help the most? _____ _____

What (if anything) aggravates your condition? _____

Do you have any other medical conditions or would you like to explain anything else? Y / N _____

_____

Patient signature _____ Date ____/____ /_____

Therapist Notes:_____

_____

Massage Therapist signature _____ Date ____/____ /____