Marian Wolfe Dixon, MA, LMT
Oregon License #3902, 6901 SE 65th Avenue, Portland, OR 97206
phone 503-232-7282 fax 503-244-1815

MEDICAL MASSAGE INTAKE

Patient Name ____________________________ Date _____________ DOB _____________

Address ______________________________ City, State _______________Zip _________

Phone (Home) ____________________ (Cell) ______________ (Work) ________________

email ________________________________Which number to leave messages? H C W

Male ____ Female ____ How did you hear about me? ______________________________

Occupation _____________________________ How many work days missed? __________

Emergency Contact ____________________ Relationship ____________Phone _________

THE ACCIDENT/ SURGERY

Date of Injury/surgery ________ Was this a motor vehicle accident (MVA)? ____

Describe and/or draw the incident. Include applicable information such as environmental conditions; lacerations, bruises, breaks sustained; loss of consciousness; immediate care/treatment received; type of surgery; implants/hardware received. For MVA describe the collision, pavement conditions, speeds, directions, seatbelts worn, airbags deployed, etc.

RESULTS OF ACCIDENT (skip if not applicable, you have a separate section for health history)

How did you feel right after the accident? ____

Did you go to hospital or urgent care?____________ How long after?__________Name of hospital ____________

How did you get there? Private vehicle ____ ambulance _____

Treatment(s) received since accident? ____

____x rays? ____________

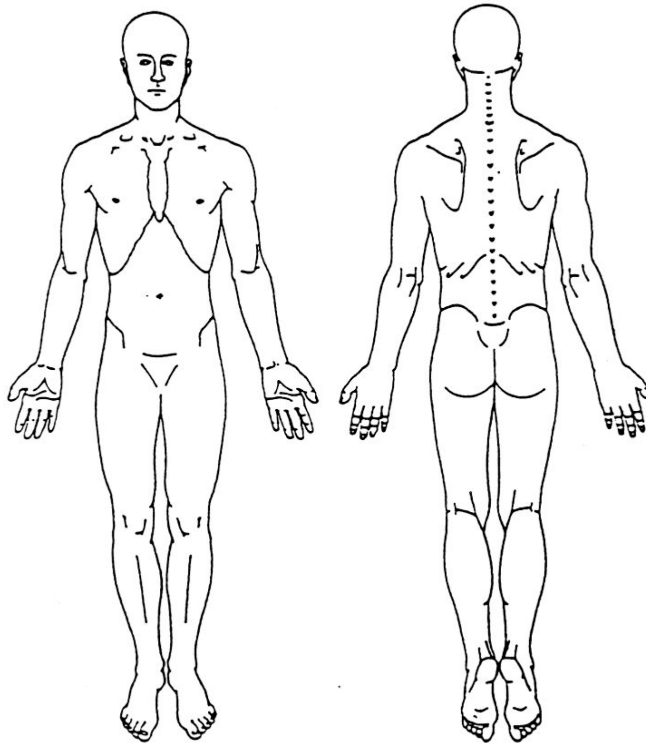
Check where you have had symptoms since the accident: Head ___ Jaw ___ Neck ___ Shoulder __ Arm____

Wrist ____ Hands ____ Chest ____ Abdomen _____ Upper Back _____ Mid Back _____ Low Back _____

Hips _____ Buttocks _____ Thighs _____ Knees _____ Legs ____ Ankles _____ Feet _____

Marian Wolfe Dixon, MA, LMT
Oregon License #3902, 6901 SE 65th Avenue, Portland, OR 97206
phone 503-232-7282

Mark areas where you are having pain, tightness or other symptoms on the diagram.



Check the symptoms you have had recently / **since** the accident:

___ blurred vision
___ breathing difficulties
___ coughing
___ disorientation
___ dizziness
___ PAIN, discomfort, aches:
    ___ sharp ___ dull ____tender ____throbbing ___shooting
___ears buzzing/ringing

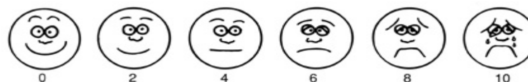
___ irritable/moody
___ muscle spasms/cramping
___ sounds: popping/grinding
___ numbness/tingling
___ headaches
___ elimination problems

___ insomnia
___ sneezing
___ nausea
___ stress
___ weakness
___ fatigue
___ swelling

What makes your symptoms worse?____

What relieves symptoms even temporarily?___________________________________

General level of pain/discomfort today. Make an X on the scale below.



Marian Wolfe Dixon, MA, LMT
Oregon License #3902, 6901 SE 65th Avenue, Portland, OR 97206
phone 503-232-7282

MEDICAL HISTORY

Check conditions below that applied to you **at any time (2 checks for current, 1 for past conditions)**:

___ circulation disorders ___ fibromyalgia ___ sleep disorders
___ heart disease ___ cancer ___ PMS
___ varicose veins ___ HIV/AIDS ___ chronic pain
___ digestive disorders/ disease ___ depression ___ stress
___ frequent stomach aches/gas ___ diabetes ___ allergies
___ radiation Tx ___ skin conditions ___ arthritis
___ lymph node removal ___ surgery in past 5 years ___ previous trauma
___ muscular disorders/diseases ___ broken bone/ past 3 yrs ___ frequent HA
___ wear contacts (currently) ___ currently pregnant ___ _________due date
____ seizures ____ chemotherapy ____ OTHER

Comment on any checked boxes here

____

Please read the statement below and sign where indicated.

Medical massage therapy is intended to enhance recovery from a medical condition; for some conditions massage is contraindicated. Massage is not a substitute for medications or medical treatment; please consult with your physician for medical conditions you have. It is outside the scope of therapeutic massage to diagnose illness/disease; prescribe medications, supplements or treatments; or perform high velocity spinal manipulations.

By signing below I agree that: All of the information I supplied above is true and correct to the best of my knowledge and it is my responsibility to update my massage practitioner of any changes in health or treatment; I will adhere to billing and cancellation policies; and I authorize the office of Marian Wolfe Dixon, MA, LMT to release requested medical information to the insurance company and other parties necessary to process and pay my claims.

Patient Signature ___________________________________ **Date**_________