

# Valerie L. Thompson ~ Licensed Massage Therapist

1419 N. State Street, Bellingham, WA 98225

360.734.2882

Name : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency contact and phone number: \_\_\_\_\_

## Health/Medical History

Have you received professional massage before? Yes No How recently? \_\_\_\_\_

Current medications: \_\_\_\_\_

Recent surgeries or illnesses: \_\_\_\_\_

Known allergies or sensitivities: \_\_\_\_\_

Please list activities you participate in regularly (e.g. exercise, repetitive tasks) :

\_\_\_\_\_  
\_\_\_\_\_

Please review the conditions table and explain if you answer yes to a specific condition.

Chronic Pain?	Neurological Conditions?
Arthritis?	High Blood Pressure?
Osteoporosis?	Numbness?
Diabetes?	Joint Swelling?
Skin Conditions?	Varicose Veins?
Cardiac Conditions?	Hearing Aids?
Circulatory Conditions?	Pregnant? Due Date:
Other:	

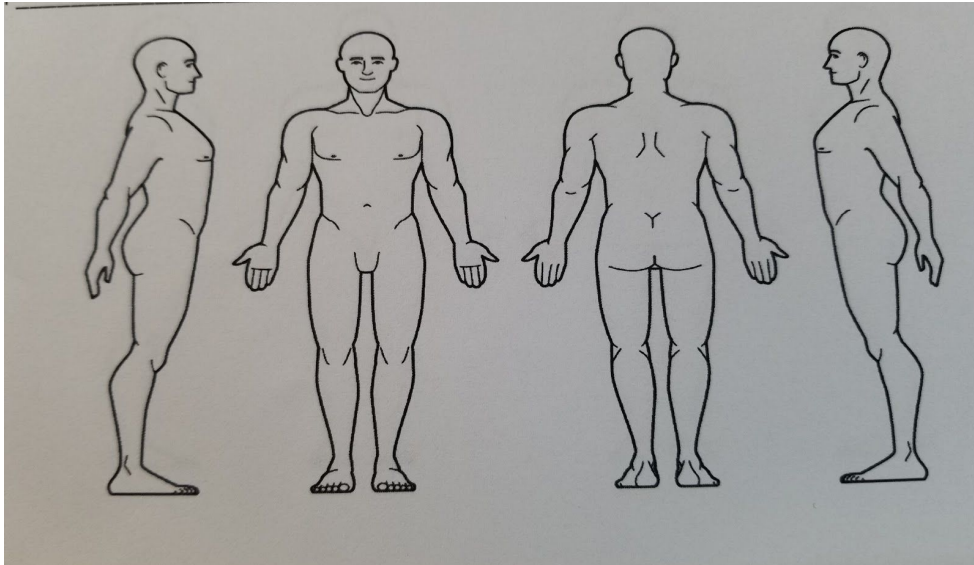
What are your current concerns and goals for treatment?

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Please mark areas of pain, tension, or concern:



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**Consent for Care:** It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my therapist of any changes in my health. \_\_\_\_\_ **Initial**

**Confidentiality:** Client's records and sessions will be kept confidential and will not be shared with anyone without the client's written consent. \_\_\_\_\_ **Initial**

**Office Policy:** Cancellations require 24 hour notice to insure that I can re-book the appointment. A \$50 cancellation fee will be assessed if appointments are cancelled less 24 hours in advance. \_\_\_\_\_ **Initial**

Please reschedule your appointment if you have a cold, the flu, or an illness. I reserve the right to cancel your appointment last minute if you are too ill to receive massage.  
\_\_\_\_\_ **Initial**

Signature \_\_\_\_\_ Date \_\_\_\_\_

