

HEALTH QUESTIONNAIRE

Name: _____ DOB: _____
Address: _____ State: _____ Zip: _____
Phone: (Home) _____ (Work) _____ (Cell) _____
Occupation/Employer: _____ What brings you here: _____
Emergency Contact: _____ Phone: _____
Primary Health Care Provider: _____ Phone: _____
Permission to consult with primary provider: Please initial if yes. Yes _____ No
E-mail address: _____
How did you hear about this place: _____

*If you have a specific medial condition or symptom, receiving or performing massage may be contraindicated or require modification. A referral from your primary care provider may be requested prior to receiving &/or performing massage.
DISCLAIMER: This place of business will not be held liable for any injury or condition that arises from application of massage despite completion of this form. The form is intended as an assessment tool that is routinely used in the massage profession and serves as a guide for application of massage.

Massage History/ Treatment Information

- Have you received a professional massage before? _____ Date of last massage: _____
- What results do you want from your massage sessions?

- Prioritize the areas of your body that you would prefer to be massaged?

- Are there any areas of your body that you '**DO NOT**' want massaged:
Face Scalp Neck Chest Shoulders Stomach Back Arms
Hands Glutes Legs Feet
- Are you on any medications (List them)? _____
- Are you currently seeing a medical practitioner? If yes, please explain. yes no

- List stress reduction and exercise activities. Include frequency.

Previous History

- Surgeries: _____

- Accidents: _____

Health History

Integumentary System (Skin)

- Warts/moles _____
- Psoriasis _____
- Skin allergies _____
- Rashes _____
- Scars _____
- Cosmetic surgery _____
- Bruise easily _____
- Other: _____

Digestive / Urinary System

- Cirrhosis _____
- Ulcer _____
- Gallstones _____
- Hepatitis _____
- Irritable Bowel Syndrome _____
- Kidney stones _____
- Reflux esophagitis _____
- Bladder infection _____
- Eating disorder _____
- Other: _____

Circulatory

- Heart disease/condition _____
- High Blood Pressure _____
- Low Blood Pressure _____
- Varicose Veins _____
- Diabetes _____
- Clotting disorders _____
- Edema _____
- Cold/flu/fever (Currently) _____
- Lupus _____
- Other: _____

Respiratory System (Breathing)

- Sinus problems _____
- Tuberculosis _____
- Asthma _____
- Emphysema _____
- Other: _____

Musculo-skeletal System (Muscle)

- Fibromyalgia _____
- Rheumatoid Arthritis _____
- Osteoarthritis _____
- TMJ dysfunction _____
- Strains, sprains, tendonitis _____
- Bursitis _____
- Carpal tunnel syndrome _____
- Thoracic outlet syndrome _____
- Cramping, spasms, soreness _____
- Broken or fractured bones _____
- Persistent pain _____
- Loss of motion or mobility _____
- Difficulty with prolonged stance _____
- Unable to comfortably lie on both sides _____
- Other: _____

Nervous System

- Multiple Sclerosis _____
- Numbness/tingling _____
- Headaches _____
- Stroke _____
- Herpes/Shingles _____
- Sleep disorder _____
- Fatigue _____
- Chronic Pain _____
- Other: _____

Reproductive System

- Pregnant ? Stage _____
- PMS _____
- Other: _____

Other

- Hearing impaired
- Visually impaired
- Cancer
- Alcoholism/substance abuse
- Heavy caffeine or nicotine user
- Physical abuse
- Psychological condition
- Other: _____

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well being is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. 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 that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

Signature: _____ **Date:** _____