

# HEALTH QUESTIONNAIRE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Occupation/Employer: \_\_\_\_\_ What brings you here today: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
How did you hear about me: \_\_\_\_\_

\*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? \_\_\_ How frequently? \_\_\_\_\_

• 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 all)?  
\_\_\_\_\_  
\_\_\_\_\_

• 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

- Ulcer \_\_\_\_\_
- Hepatitis \_\_\_\_\_
- Irritable Bowel Syndrome \_\_\_\_\_
- Kidney stones \_\_\_\_\_
- Bladder infection \_\_\_\_\_
- 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 \_\_ Week: \_\_\_\_\_
- Previous Pregnancy Loss: \_\_\_\_\_
- Reason if known \_\_\_\_\_
- PMS \_\_\_\_\_
- Other: \_\_\_\_\_

### Other

- Hearing impaired
  - Visually impaired
  - Cancer
  - Alcoholism/substance abuse
  - Heavy caffeine or nicotine user
- 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:** \_\_\_\_\_