

HEALTH QUESTIONNAIRE

Name: _____ DOB: _____
Address: _____ State: _____ Zip: _____
Phone: (Home) _____ (Work) _____ (Cell) _____
Occupation/Employer: _____
Emergency Contact: _____ Phone: _____
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.

• Primary focus during visit/What brings you here?

• Are there any areas of your body that you **'DO NOT'** want massaged: _____

• Are you on any medications (List them)? _____

• Are you currently seeing a medical practitioner? If yes, please explain. yes no

• Surgeries: _____

• Accidents: _____

Considerations

*Numbness/Tingling _____

*Asthma or Skin Allergies _____

*Jaw Pain _____

*Currently Pregnant _____

*Hi/Low blood pressure _____

*Diabetes _____

*Herpes (1 or 2) _____

*Other contagious Illness _____

*Osteoarthritis _____

*Headaches _____

*Persistent Cough _____

*Hear Condition _____

*Digestive disorder _____

*Cancer _____

*AIDS or HIV+ _____

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 nay 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: _____