Massage Questionnaire

Please complete this questionnaire before your first appointment and submit it to Massage Therapy, GX 225. We require that this form be submitted several days prior to your initial visit.

Name:	**Today's Date:**	Date of Birth:
Home Phone: ( )	Occupation:	Weight:
Work Phone: ( )	Mobile Phone: ( )	
Emergency Contact Name:		Relationship:
Emergency Contact Phone : Work ( )	Home: ( )	Mobile: ( )
Name of Employee with whom affiliated:		Work Phone: ( )

CLIENT CONDITION

What are your symptoms? ____

____

Type of Pain? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps

☐ Stiffness ☐ Swelling ☐ Other ____

When did your symptoms appear? ____

What treatment have you already received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Massage Therapy ☐ Chiropractic Care ☐ Chemo ☐ None ☐ Other

____

____

Have you been under the care of a health care provider (chiropractor, physician, psychotherapist, alternative practitioner) in the past year? No ☐ Yes ☐

For treatment of____

Practitioner's Name(s)____

Please list any surgeries and injuries (bone breaks/fractures, dislocations, sprains, head/neck/spine injuries, whiplash, vehicle accidents, falls, or other trauma) with approximate dates.

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Have you ever been hospitalized? No ☐ Yes ☐ (describe/dates)____

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Are you pregnant? No ☐ Yes ☐ Due date: ________________ Previous Childbirth dates: ______________________________

Current Medications	Vitamins/Herbs	Allergies	Exercise/Work Activity	Lifestyle
			☐ None	☐ Smoker Packs/Day:
			☐ Moderate	☐ Alcohol Drinks/Week:
			☐ Daily	☐ Caffeine Cups/Day:
			☐ Heavy	Stress Level: ☐ High ☐ Medium ☐ Low

HEALTH HISTORY

Please check all conditions you have experienced.

☐ Anemia	☐ Diabetes	☐ Hepatitis	☐ Osteoporosis	☐ Stroke
☐ Appendicitis	☐ Emphysema	☐ Hernia	☐ Pacemaker	☐ Thyroid Issue
☐ Arthritis	☐ Epilepsy	☐ Hernia Disk	☐ Pinch Nerve	☐ Tumors, Growth
☐ Asthma	☐ Fibromyalgia	☐ High Blood Pressure	☐ Rheumatoid Arthritis	☐ Ulcers
☐ Blood Clots	☐ Fractures	☐ Lymphedema	☐ Sinus Problems	☐ Varicose Veins
☐ Bursitis	☐ Head Injuries	☐ Migraine Headaches	☐ TMJ – Jaw pain	☐ Whiplash
☐ Cancer	☐ Heart Disease	☐ Multiple Sclerosis	☐ Tendonitis	☐ Other

Do you have any current medical condition not listed above? No ☐ Yes ☐ (describe) ________________________________

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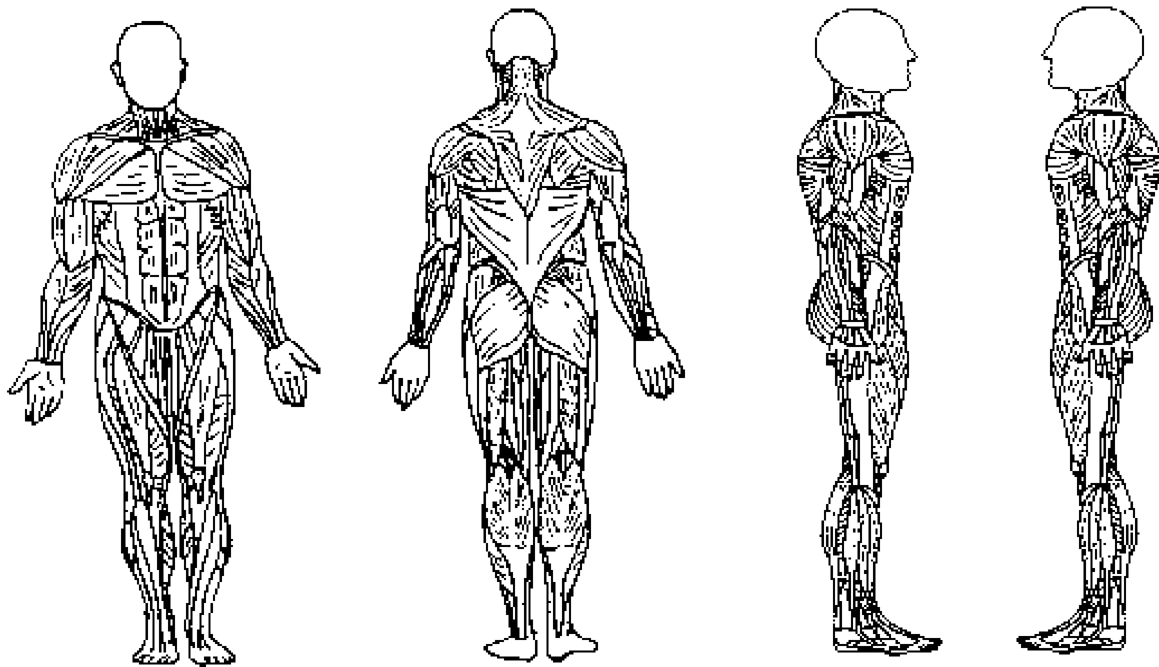
Please shade areas in the figures below which correspond to any joint or muscle pain you have been experiencing:



PLEASE READ AND SIGN THE FOLLOWING

I have completed the information above and have listed all known medical conditions and physical limitations. I will inform the massage practitioner of any changes in my physical health, medications, treatments, recent injuries, open wounds, skin conditions, or areas of concern **before** each massage session. I understand that massage is not a replacement for medical care or diagnosis and take responsibility for consulting a qualified healthcare provider for any physical ailments.

I hereby acknowledge that all appointments, rescheduling requests and cancellations must be made by dialing 531-4466 and agree to pay for all scheduled appointments that I am unable to keep unless I leave a message at 531-4466 at least 24 hours in advance.

____ ________________

Signature Date