Your Life...Your Wellness™

Jenifer Olson, Owner, BA, LMT, NCTMB

Phone: 305-619-2195 e-mail: tranquil_touch@live.com

Health Questionnaire

Name: _____ Date of Birth: _____

Address: _____
(Street) (City, State) (Zip)

Phone: (_____)_____ ☐ Work ☐ Home ☐ Cell Occupation: _____

Emergency Contact Information: _____ (_____)_____
(Name) (Phone)

Primary Care Provider: _____ (_____)_____
(Physician Name) (Phone)

Please take a moment to carefully respond to the following questions and sign where indicated. Certain medical conditions may be contraindicated for massage.

Have you had massage before? YES NO

Have you had reflexology before? YES NO

What type of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

Are you currently pregnant? YES NO

Do you smoke? YES NO Number of packs per week _____

Do you exercise routinely? YES NO How many hours per week _____

Do you wear ☐ Glasses? ☐ Contact Lenses?

Do you have any allergies? YES NO

Please list allergies:

_____

_____

_____

Please list any surgeries or hospitalizations you have had (including childbirth):

_____
(Type of surgery/hospitalization) (Year)

_____

_____

_____

Have you ever been in an accident? (Please list all including falls and indicate what type of injury (if any) occurred.)

(Type of accident)	(Type of injury)	(Year)

Are you currently taking any medications? (Please list all including supplements and/or any Over-The-Counter Medications also.)

(Medication)	(Dosage)	(Taken how often)

Please indicate if you or a family member currently have or have previously had any of the following conditions:

Condition	Self	Parent	Sibling	Grandparent	Child
High blood pressure	☐	☐	☐	☐	☐
Low blood pressure	☐	☐	☐	☐	☐
Heart problems	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Blood clots	☐	☐	☐	☐	☐
Varicose veins	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Hypoglycemia	☐	☐	☐	☐	☐
Hyperglycemia	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐
Frequent headaches	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Sexually Transmitted Disease(s)	☐	☐	☐	☐	☐
Communicable Disease(s)	☐	☐	☐	☐	☐

Do you want essential oils used topically during your massage? Yes No

Please provide any additional information regarding any of your diagnoses that may assist with your therapeutic sessions with Tranquil Touch, L.L.C.

_____

_____

_____

Are you in any pain? Please describe.

_____

_____

_____

What are your goals for massage?

_____

_____

_____

I, _____(print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I have received a copy of the Massage Therapy Policies and Procedures, in which I have read, understand and have had the opportunity to ask questions.

I understand that the appointment cancelation fee is 50% of the scheduled massage price for all cancellations within 12 hours of appointment time.

_____

Client Signature or Legal Guardian's Signature AND relationship

_____

Today's Date