Massage Therapy Health Questionnaire

Your health history is being requested for your safety. Massage affects all systems in the body. Your response to the following questions will help us create a session specific for you and your needs. All information that you provide is kept confidential.

Name: ____________________ Today's Date: __________ DOB: __________

Address: ____________________ City/State/Zip: ____________________

Home Phone: ____________________ Cell: __________ Text OK? ❑ Yes ❑ No

Email: ____________________ May we add you to our email list? ❑ Yes ❑ No

Occupation: ____________________ Referred by: ____________________

Have you ever had a professional massage? ❑ Yes ❑ No If yes, how often? ____________________

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

What is your goal for massage today?

❑ Relaxation, Full Body (I want to relax)
❑ Therapeutic (relieve stress/tension)
❑ Clinical (localized pain for minor injury, chronic conditions)

Check ✗ any of the following symptoms you are currently experiencing:

❑ Low Back Pain
❑ Sciatic Pain
❑ Hip Pain
❑ Leg Pain/Cramps
❑ Foot Pain/Cramps
❑ Neck Pain
❑ Tension Headaches
❑ Migraine Headaches
❑ Jaw Pain
❑ Ringing in Ears L / R
❑ Pain Between Shoulder Blades
❑ Tension Across Top of Shoulders
❑ Numbness/Tingling in Arms/Hands
❑ Numbness/Tingling in Legs/Feet
❑ Abdominal Pain

Have you ever seen your primary physician for any of these conditions? ❑ Yes ❑ No

Which of the above is the worst? ____________________

How long have you had it? __________ **How often does it occur?** __________

What does it feel like? (Describe: sharp, dull, achy, burning)

____

What have you done to make the symptoms of this problem feel better?

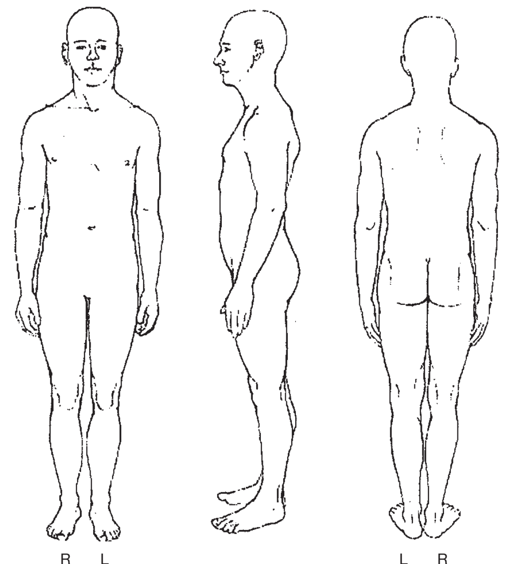
❑ Ice / Heat ❑ Medication ❑ Physical Therapy ❑ Chiropractic ❑ Stretching
❑ Trigger Point Injection / Cortisone Shots ❑ Other__________

Has anything you've tried thus far helped your problem? ❑ Yes ❑ No

On a scale from 1-10, 1=lowest, 10=highest, rate your levels of:

Stress ________ Pain ________ Energy ________

****On the diagram to the right, please ❍ circle any areas where you carry tension and stress, put an "X" where you are experiencing pain and/or discomfort, put an arrow → if the pain radiates.****



Please complete side 2 →

General Health Information

Please take a moment to carefully read the following health conditions and check all that apply to you. If you check yes to any of the following, please explain as clearly as possible. If you have a specific medical condition, or symptoms of a medical condition, massage and bodywork may be contraindicated. A referral from your primary care provider may be required prior to massage service being provided.

Health Conditions	No	Yes	Please Explain
Allergies / Asthma (Respiratory)	☐	☐	
Arthritis	☐	☐	
Cancer or Tumors	☐	☐	
Cardiovascular / Circulatory	☐	☐	Please circle all that apply: Anemia, Angina, Arteriosclerosis, Congestive Heart Failure, Phlebitis/Thrombosis, Heart Attack, Heart Murmur, Hemophilia, Hypertension (High Blood Pressure), Varicose Veins, Other:
Contact Lenses / Dentures / Prosthetics	☐	☐	
Diabetes	☐	☐	Type: ____________
Difficulty Sleeping / Tired / Fatigued / Low Energy	☐	☐	
Depression / Anxiety / Post-Traumatic Stress	☐	☐	
Gastrointestinal Problems	☐	☐	
Infectious Diseases	☐	☐	
Injuries / Accidents	☐	☐	☐ Fully Recovered
Osteoporosis	☐	☐	
Pregnancy If Pregnant, how many weeks: ___________	☐	☐	Please circle all that apply: Currently pregnant, Postpartum (within past 6 weeks) spontaneous or elective abortion (within past 6 weeks), currently breast feeding
Medications (Please List)			
Skin Conditions	☐	☐	Please circle all that apply: Acne, Abrasions/Cuts, Birthmarks/ Moles, Bruises, Dermatitis, Eczema, Herpes, Hives, Infections, Poison Ivy/Oak/Sumac, Psoriasis, Skin tags, Sunburns, Warts, Scars, Other:
Surgeries	☐	☐	☐ Fully Recovered Type: ______________________________

Please explain any other health related information that you think would be helpful to your therapist: (fibromyalgia, multiple sclerosis, carpal tunnel, lupus, neurological disorders, etc.)

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I understand that the massage/bodywork 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 practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork 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 of which I am aware. I understand that massage/bodywork practitioners 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/ bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: ____ Date: ____________________

Therapist Signature: ______________________________________ Date: ____________________

Consent to Treatment of Minor: By my signature below, I hereby authorize ____________________ to administer massage, bodywork, or therapeutic techniques to my child or dependent, ____________________________, as they deem necessary based on the information provided on this form. I agree to be present during the intake and massage session, and ask questions on behalf of my minor child.

Signature of Parent or Guardian ______________________________________ Date ______________