

# 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) \$70/hr
- Therapeutic (relieve stress/tension) \$70/hr
- Clinical (localized pain for minor injury, chronic conditions) \$80/hr

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Low Back Pain    | <input type="checkbox"/> Neck Pain             | <input type="checkbox"/> Pain Between Shoulder Blades    |
| <input type="checkbox"/> Sciatic Pain     | <input type="checkbox"/> Tension Headaches     | <input type="checkbox"/> Tension Across Top of Shoulders |
| <input type="checkbox"/> Hip Pain         | <input type="checkbox"/> Migraine Headaches    | <input type="checkbox"/> Numbness/Tingling in Arms/Hands |
| <input type="checkbox"/> Leg Pain/Cramps  | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Numbness/Tingling in Legs/Feet  |
| <input type="checkbox"/> Foot Pain/Cramps | <input type="checkbox"/> Ringing in Ears L / R | <input type="checkbox"/> 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?

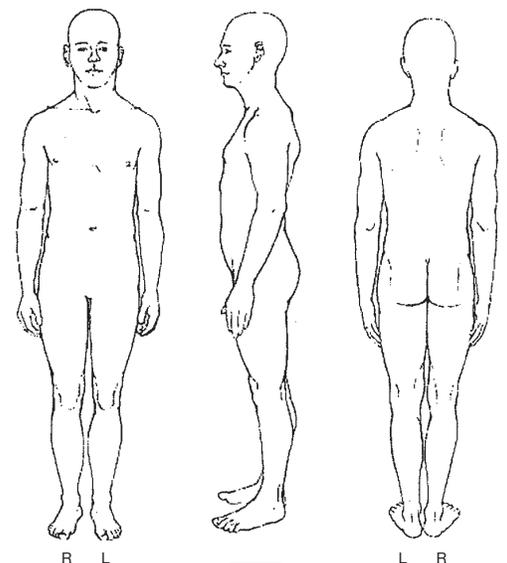
- Ice / Heat  Medication  Physical Therapy  Chiropractic  Stretching
- Trigger Point Injection / Cortisone Shots  Other \_\_\_\_\_

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.\*\***



## 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)	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer or Tumors	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular / Circulatory	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____
Difficulty Sleeping / Tired / Fatigued / Low Energy	<input type="checkbox"/>	<input type="checkbox"/>	
Depression / Anxiety / Post-Traumatic Stress	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	
Injuries / Accidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Fully Recovered
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Pregnancy If Pregnant, how many weeks: _____	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 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 \_\_\_\_\_