Massage Therapy History Questionnaire

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A Complete Health and Wellness Center

Please **PRINT, ANSWER**, and **FILL IN ALL** the questions/blanks listed in this form. Date_____/_____/20_____

Full Name (First, Middle Initial, and Last) _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ (H) _____ (W) _____

Email Address _____ SS#_____

Occupation _____ Place of Employment _____

Height _____ Weight _____ DOB _____ Age _____

Sex _____ Marital Status _____

Emergency Contact: Name _____

Relationship _____ Phone _____ Alt Phone _____

Physician _____ Phone _____

Is your physician aware of you receiving a massage? _____

Why have you decided to have a Massage Therapy session(s)? Please check all that apply:
_____ Dr. Suggested or prescription _____ Ninth Amendment "right to self treat"

Please state your expectations from receiving a massage?_____

Massage Therapy

Have you ever received a professional massage? _____

If so, when was your last? _____

How often do you have? _____

Where is your primary area of pain/discomfort? _____

Where are your secondary areas of pain/discomfort? _____ _____

When did you first notice this pain? _____

What aggravates or diminishes the pain/discomfort? _____

Are there any areas you do NOT want to have massaged? Please list. _____

Please check all conditions you have or have experienced regardless of how long ago. Please be as truthful as possible.

Joint/Soft Tissue Pain
___ Arms
___ Shoulder
___ Elbows
___ Hands
___ Fingers
___ Neck
___ Upper Back
___ Mid Back
___ Lower Back
___ Hips
___ Legs
___ Knees
___ Feet
___ Toes
___ Sciatica
___ Degenerative Discs
___ Osteoarthritis
___ Rheumatoid Arthritis

Cardiovascular
___ High Blood Pressure
___ Low Blood Pressure
___ Coronary Heart Disease
___ Heart Attack
___ Phlebitis
___ Stroke/CVA
___ Pacemaker
___ Heart Murmur
___ Palpitations
___ Varicose Veins
___ Swelling of the Ankles
___ Poor Circulation

Skin
___ Rashes
___ Itching
___ Bruise Easily
___ Dryness
___ Boils
___ Eczema

Digestive
___ Poor Appetite
___ Gas/Belching
___ Constipation
___ Diarrhea
___ Nausea
___Ulcer
___ Vomiting
___ Alcohol

Eye, Ear, Nose, Throat
___ Allergies
___Frequent Colds
___Glasses or Contacts
___Hearing Aid/Loss of Hearing
___ Sinus Infections
___Swollen Glands

Reproductive (Females)
___ Pregnant, Due Date _____
___ Painful Menstruation
___ Heavy Flow
___Irregular Cycle
___ Swollen Breasts
___ Menopausal
___ Premenopausal
___ Postmenopausal
___ Birth Control, Type _____

Respiratory
___ Chronic Cough
___ Bronchitis
___ Asthma
___ Hay Fever
___ Difficulty Breathing
___ Smoking
___ Emphysema
___Pneumonia

Infections
___ Hepatitis
___Tuberculosis
___ HIV
___ AIDs
___Herpes
___ Cold
___ Flu
___ Yeast
___Athlete's Foot
___ Warts
___ STDs

General Symptoms
___ Fainting
___ Dizziness
___ Loss of Sleep
___ Fatigue
___ Nervousness
___ Sudden Weight Loss/Gain
___ Numbness/Tingling
___ Paralysis
___Headaches
___Migraines

Other Conditions
___ Neurological Conditions
___ Epilepsy
___Diabetes, Type _____
___ Anaphylactic
___ Cancer, Type _____
___ Arthritis, Type _____
___Insomnia
___ Hemophilia
___Kidney/Bladder Problems

Please explain any conditions NOT listed previously. _____

I certify and affirm that I have listed 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.

Client's Name/Signature _____

Date _____ (***Clients under the age of 18, signature of parent/legal guardian is required.)***