HEALTH QUESTIONNAIRE

Name: _____ DOB: _____

Address: _____City_____ State: _____ Zip: _____

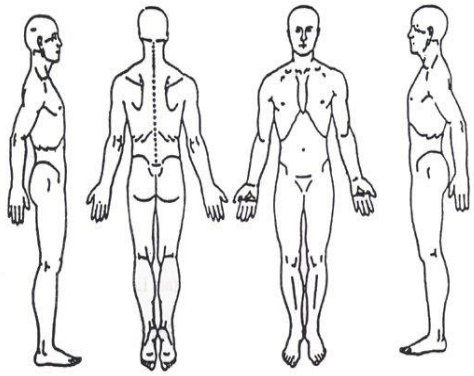
Phone: (Home) _____ (Work) _____ (Cell) _____

What is your employment: _____ What brings you here: _____

Emergency Contact: _____ Phone: _____

How did you hear about this place: _____ E-mail address: _____

*****If you have a specific medial condition or symptom, receiving or performing massage may be contraindicated or require modification. A referral from your primary care provider may be requested prior to receiving &/or performing massage.
DISCLAIMER: This place of business will not be held liable for any injury or condition that arises from application of massage despite completion of this form. The form is intended as an assessment tool that is routinely used in the massage profession and serves as a guide for application of massage.



*****Have you received a professional massage before? _____
*****Are you on any medications (List them)? _____
_____

***Are there any areas of your body that you 'DO NOT' want massaged:**
(Face) (Scalp) (Neck) (Upper Chest) (Shoulders) (Stomach) (Upper back) (Mid back) (Lower back) (Arms) (Hands) (Glutes-Buttocks) (Legs) (Feet)

***Please circle the condition/s that you have now or had experienced in the past & add comments to clarify.**

Integumentary System (Skin)

- Boils
- Fungal infections
- Herpes Simplex
- Warts/moles
- Eczema
- Psoriasis
- Skin Cancer
- Skin allergies
- Rashes
- Burns
- Severe Sunburn
- Scars
- Cosmetic surgery
- Bruise easily
- Other: _____
- Comments: _____

Circulatory / Lymph / Endocrine System

- Anemia
- Phlebitis
- Heart disease/condition
- High Blood Pressure
- Low Blood Pressure
- Varicose Veins
- Diabetes
- Clotting disorders
- Edema
- Hodgkin's disease
- AIDS, HIV
- Chronic Fatigue Syndrome
- Lupus
- Cold/flu/fever (Currently)
- Hypo/Hyperthyroidism
- Leukemia/lymphoma
- Other: _____
- Comments_____

Respiratory System (Breathing)

- Sinus problems
- Tuberculosis
- Asthma
- Emphysema
- Other: _____
- Comments: _____

Musculo-skeletal System (Muscle)

- Fibromyalgia
- Rheumatoid Arthritis
- Osteoarthritis
- TMJ dysfunction
- Strains, sprains, tendonitis
- Bursitis
- Carpal tunnel syndrome
- Thoracic outlet syndrome
- Cramping, spasms, soreness
- Broken or fractured bones
- Persistent pain
- Loss of motion or mobility
- Difficulty with prolonged stance
- Unable to comfortably lie on both sides
- Other: _____
- Comments: _____

Digestive / Urinary System

- Cirrhosis
- Ulcer
- Gallstones
- Hepatitis
- Irritable Bowel Syndrome
- Kidney stones
- Reflux esophagitis
- Bladder infection
- Eating disorder
- Other: _____
- Comments: _____

Nervous System

- Multiple Sclerosis
- Spinal cord injury
- Brain injury
- Numbness/tingling
- Headaches
- Stroke
- Seizure disorder
- Reduced sensation
- Other:_____
- Comments: _____

Reproductive System

- Breast Cancer
- Ovarian cysts
- Painful Menstruation
- Pregnant
- Prostate Cancer
- Pelvic Inflammatory Disease
- Other: _____
- Comments: _____

Other

- Hearing impaired
- Visually impaired
- Insomnia
- Cancer (Other than specified above)
- Alcoholism/substance abuse
- Heavy caffeine or nicotine user
- Physical abuse
- Psychological condition
- Using over the counter medication
- Accidents: _____
_____
- Surgery other than specified above: _____
_____

Other conditions: _____
Comments: _____

I have stated all conditions that I am aware of and that this information is true and accurate to the best of my knowledge. I agree to inform my massage therapist immediately of any change in conditions as stated above. I acknowledge that this information is confidential and intended for review by fellow massage therapists; that a medical referral may be requested of me; and that ''This place of business' is not held liable for the management or arising of conditions.

Signature: _____ Date: _____