Health Questionnaire

Name:_____D.O.B _____/_____/_____
Address: _____
Cell # _____ Home Phone #_____
Email _____ Business #_____
Emergency Contact: _____Phone# _____

How did you find out about us?

Referred ____ Sign ____ Facebook____ Twitter_____ LinkedIn_____ Website_____
Yelp____Total welness_____Google____Instagram_____Others_____
Referred By_____

Prohibiting Factors

1- Any known allergies and or sensitivities to vegetables, fruit or seeds? Yes ( ) No ( )
If yes please explain_____
2- Do you sit for long hours at workstation, computer or driving? Yes ( ) No ( )
3- Do you perform any repetitive movement in your work, sport or hobby?
Yes ( ) No ( ) If is yes please explain _____
_____

Clients Medical Information

Do you have or had any of the following conditions? Check appropriate lines.

___High Blood Pressure
___Low Blood Pressure
___Heart Condition
___Nervous Condition
___Any Contagious Disease
___Organ Disfunction
___HIV virus
___Allergies
___Skin Disorders
___Leg Pain
___MS
____Stiff Neck
____Whiplash
____Serious Accidents
____Varicose Veins
____Inflammation
____Insomnia
____Headaches
____Neck Pain
____Pregnancy
____Hand Pain
____Others
____Recent Surgery
____Fractures
____Recent Fever
____Arthritis
____Diabetes
____Epilepsy
____Cancer
____Shoulder Pain
____Foot Pain
____Lower Back Pain

Activities	Frequency (times per week)
____ Walking / jogging	_____
_____Running	_____
_____Swimming	_____
_____Aerobics	_____
_____Bicycling	_____Others_____

Massage Information

Do you have any particular goals in mind for this massage session:_____
_____
Have you ever had a professional massage before? Yes ( ) No ( )
The level of stress you feel today is: Low ( ) Medium ( ) High ( )
How has stress affected your health? Muscle Tension ( ) Anxiety ( )
Insomnia ( ) Irritability ( ) Others _____
What is your major discomfort? _____
Any others comments / requests you would like to add with regards to receiving your massage today?_____

Policies

Draping will be used during the session. Only the area being worked will be uncovered.
1- I understand that: 24 hour notice is required for cancellation of an appointment, and that a fee of 50% of the cost of the schedule service will be charge to me when this courtesy is not provided. Initial _____ Date _____
2- I understand that: I am to arrive 10 min before my schedule appointment. This prevents any stress in scheduling to you or the therapist, have a fresh beverage, use the facilities, turn off your cell phones and relax before your session.
Initial _____ Date _____
3- I understand that: I am to notify my massage therapist of any changes in my health care / medical history. Initial _____ Date _____

I, _____ (print your 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 pressure and/or strokes maybe 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 or other qualified medical specialist for any mental or physical adjustments, diagnose, prescribe or treat any physical or mental illness. 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

Signature : _____ Date : _____