Massage Therapy Questionnaire

Name:__________________________________________  Date of Initial Visit:_______________
Address: ________________________________________________________________________________
City, State, Zip: __________________________________________________________________________
Phone: (Day) ____________  (Evening) ____________  (Cell) ____________  (Email)_________________
Date of Birth: ____________________________________
Occupation: ____________________________________  Employer: ________________________________
Referred By: ____________________________________  Physician: _________________________________
1) Have you ever had Massage Therapy before?                         Yes_____  No_____
2) Do you have difficulty lying on your front, back, or side?     Yes______ No______
3) Do you have allergic reactions to oils, lotions, ointments, liniments, or other substances put on your skin?  
   Yes_____  No_____  If yes, please explain__________________________________________________
4) Do you wear contact lenses ( ), dentures ( ), a hearing aid ( )?
5) Do you experience stress in your work, family, or other aspects of your life?  Yes____ No____  
   -How would you describe your stress level?  Low____ Medium ___ High ____ Very High ____
   -If high, how do you think your stress has affected your health?  Muscle Tension ( ),
   -Anxiety ( ), Insomnia ( ), Irritability ( ), Other ___________________________________________
6) For women:  Are you pregnant?  Yes ___ No ___  If yes, how many months? ______
7) What is your major complaint, if any that you want to improve? __________________________________
   ______________________________________________________________________________________
8) When did you first notice this complaint? ______________________________________________________
9) What event(s) brought it on? __________________________________________________________________
10) What activities aggravate the condition? __________________________________________________________
11) What have you done to get relief? __________________________________________________________________
12) What are your expectations for this visit? ________________________________________________________
13) Are you currently under medical supervision?  Yes ____ No ____
14) Are you currently taking any medications?  Yes ____ No ____  If yes, please list: ____________________________

Page 1 of 2
Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

**Musculo-Skeletal**
- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains and sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or Joint Disease
- Fibromyalgia
- Other

**Skin**
- Rashes
- Allergies
- Athlete's Foot
- Warts
- Moles
- Acne
- Cosmetic Surgery

**Reproductive System**
- Pregnancy:
  - Current
  - Previous
- PMS
- Menopause
- Pelvic inflammatory disease
- Endometriosis
- Other:

**Digestive**
- Nervous stomach
- Indigestion
- Constipation
- Diarrhea
- Diverticulitis
- Irritable Bowl Syndrome
- Crohn's Disease
- Adaptive aids
- Other

**Other**
- Cancer
  - Current
  - Remission
- Diabetes
- Depression
- Drug Use
- Alcohol Use
- Nicotine Use
- Caffeine Use
- Hearing Impairment
- Visual Impairment
- Infectious Disease

**Circulatory and Respiratory**
- Dizziness/lightheadedness
- Shortness of breath
- Fainting
- Cold feet or hands
- Lymphedema
- Swollen ankles
- Pressure sores
- Varicose veins
- Blood clots
- Stroke
- Heart condition
- Cerebral Palsy
- Sinus problems
- Asthma
- High Blood Pressure
- Low Blood Pressure
- Diabetes
- Other

**Nervous System**
- Numbness/tingling
- Twitching of face
- Fatigue
- Chronic pain
- Sleep Disorders
- Ulcers
- Herpes/shingles
- Spinal cord injury
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's Disease
- Other: 

Surgeries:

Please list any additional comment regarding your health and well being:

All of the above information is correct to the best of my knowledge. I realize that this session is not intended to diagnose or treat any condition that I may have, and is purely for therapeutic purposes. I will not hold the Massage Therapist liable for any exacerbated condition that was not disclosed in the above questionnaire.

Signature: ___________________________ Date: ___________________
Print Name: ________________________