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: _____

_____

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
___Osteoperosis
___Scoliosis
___Bone or Joint Disease
___Fibromyalgia
___Other

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_____

Skin
___Rashes
___Allergies
___Athlete's Foot
___Warts
___Moles
___Acne
___Cosmetic Surgery

___Other:_____

Digestive
___Nervous stomach
___Indigestion
___Constipation
___ Diarrhea
___ Diverticulitis
___ Irritable Bowl Syndrome
___ Crohn's Disease
___ Adaptive aids
___Other_____

Nervous System
___Numbness/tingling
___Twitching of face
___Fatigue
___Chronic pain
___Sleep Disorders
___Ulcers
___Paralysis
___Herpes/shingles
___Spinal cord injury
___Epilepsy
___Chronic Fatigue Syndrome
___Multiple Sclerosis
___Muscular Dystrophy
___Parkinson's Disease
___Other:_____

Reproductive System
___Pregnancy:
___Current ___Previous
___PMS
___Menopause
___Pelvic inflammatory disease
___Endometriosis
___Other:_____

Other
___Cancer___current___remission
___Diabetes
___Depression
___Drug Use_____
___Alcohol Use_____
___Nicotine Use_____
___Caffeine Use_____
___Hearing Impairment
___Visual Impairment
___Infectious Disease_____
_____

_____

_____

___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:_____