Confidential Health Questionnaire

Client Name;_____Date of Birth _____Today's Date:_____
Street Address:_____City_____Zip_____
Home Phone:_____Work Phone:_____Cell Phone:_____
Email Adress: _____ Occupation:_____

What is the reason for your visit today?_____
Is there anywhere you would like extra time spent, any area where you have muscle pain/stiffness/tension?
_____
Daily activities/sports/hobbies/exercise:_____
Posture assumed most of the day:_____
Known allergies (lotion/nuts. Etc.)_____
Are you currently taking: any prescription medication (Name and dosage)?_____
Any over the counter Medications (Tylenol, Advil, allergy, etc. please specify)?_____

Medical History (please indicate below any significant medical problems and such conditions that could influence the type or depth of work done in any given area)

☐ Skin condition (acne, rash, allergies, skin cancer, abscess, open sores) Other:
☐ Lymphatic condition (swollen glands, lymphoma, lymph edema) Other:
☐ Recent injury or accident (whiplash, sprain, deep bruise) Other:
☐ Circulatory condition (heart disease, varicose veins, phlebitis, arrhythmia, arteriosclerosis) Other:
☐ Neurological condition (sciatica, numbness/tingling of any area of skin, stroke, epilepsy, carpal tunnel) Other:
☐ Joint problems (osteoarthritis, rheumatoid arthritis, gout, hyper mobile joints, sacroiliac problems, disc) Other:
☐ Bone conditions (osteoporosis, previous fracture, cancer) Other:
☐ Headaches (migranes, PMS, tension, cluster) Other:
☐ Emotional difficulties (depression, anxiety, psychotic episodes) Other:
☐ Stress related disorders (stomach ulcers, PTSD) Other:
☐ Previous surgery (please state type and date)
☐ Other medical considerations
☐ Do you use any of the following (contacts, dentures, hearing aides, pacemaker)
☐ Blood condition (hemophilia, HIV, Hepatitis A, B, C, D, E) Other
☐ Diabetes ☐ Asthma ☐ Dizziness ☐ Are you pregnant? ☐ Blood Pressure (high, low)

Are you under medical care or supervision:_____For what condition:_____
Have you ever received Chiropractic Care:_____For what condition:_____

Consent for Care

It is my choice to receive Massage Therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments.

I acknowledge that Massage Therapy is not a substitute for medical care, medical examinations, or diagnosis. I have stated all medical conditions that I am aware of and will inform my Massage Therapist of any changes in my health status.

Signature:_____Date:_____