

Confidential Health Questionnaire – Ivey Massage Therapy

Client Name: _____ Date of Birth _____ Today's Date: _____
Street Address: _____ City _____ Zip _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____ 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)

Please list any recent injuries, surgeries, accidents, or medical treatments, include dates:

Have you been fully vaccinated against Covid-19? _____ If yes, please list date: _____
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: _____

Kindly give at least 24 hours notice if you need to change an appointment.