Health Questionnaire

Please Print Clearly. All Information shared will remain confidential

Basic Information

Name ______________________ Date ______________________
Address ______________________ Profession ______________________
City ______________________ Birthday ______________________
State & Zip ______________________ Height/Weight ______________________

History

Do you have or have you ever had any of the following conditions/illnesses/problems?
Please answer YES or NO. Please be descriptive when appropriate.

Heart Condition __________
Circulatory Problems __________
Phlebitis __________
High/Low Blood Pressure __________
Hemophilia __________
Respiratory Problems __________
Infectious Diseases __________
Cancer __________
Diabetes __________
Convulsions __________
Osteoporosis __________
Arthritis __________
Muscle/Joint Pain __________
Digestive Problems __________
Eliminatory Problems __________
Skin Problems __________
Headaches __________
Other __________

Descriptions ____

Do you wear: Contact Lenses __________ Dentures/Removable Bridgework/Orthodontics __________

Do you have any allergies or sensitivities? ______________________

Are you pregnant or attempting to become pregnant? ______________________

Are you currently under the care of a medical doctor, chiropractor, therapist, or practitioner of alternative medicinal therapies? ______________________
If yes, for what? ______________________ If no, list date of last physical __________
What medications have you taken in the last 6 months? ______________________

Please describe, including dates, area of injury, and treatment received:
Past Injuries and/or Accidents ____

Past Surgeries ____

Previous Professional Massage/Bodywork Received ______________________

List any chronic body discomfort. Please rate on a scale of 1 to 10 (1 = no pain, 10 = extreme pain)

____
____
____

Lifestyle

What do you do for exercise? ____
____

Hobbies? ____
____

What do you do to relax? ____
____

Bodywork

Previous Professional Massage/Bodywork Received ____________________________
____
____

What are you Objectives for Massage Therapy? ______________________________
____
____

Emergency Contact Information

Name ______________________________ Phone Number(s) ______________________

I, (client's name) ______________________________, do certify that the information provided is complete and accurate. Because massage should not be performed under certain circumstances, I agree to keep the massage practitioner updated as to any changes in my health profile, and I release the massage professional from any liability should I fail to do so.

I understand that the massage I receive is for the purpose of stress reduction and relief from muscular tension, spasm, or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform the massage practitioner so that the pressure or methods can be adjusted to my comfort level.

I understand that massage professionals do not diagnose illness or disease or perform any spinal manipulations, nor do they prescribe any medical treatments, and nothing said or done during the session should be construed as such. I acknowledge that massage is not a substitute for medical examination or diagnoses and that I should see a health care provider for those services.

I have read the Policies for this provider, and agree to abide by them.

Client's Signature ______________________________________ Date ______________

Consent to treat a minor:
By my signature I authorize Deirdre Toomey to provide therapeutic massage to my child or dependent.

Signature of Parent or Guardian ______________________________ Date ______________