PA Licensed Massage - General Health Questionnaire

Name _____ **Date of Birth** _____

Address _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Occupation _____ **Email** _____

Emergency Contact _____ **Phone** _____

How did you hear about us? _____

I prefer to be contacted by: **Phone -** *Home* *Work* *Cell* **Text** **Email**
(circle one)

I would like to be contacted with appointment reminders: **Yes** **No**

I would like to be added to the mail list for blog updates and current discounts: **Yes** **No**

Have you had a professional massage before? **Yes** **No**

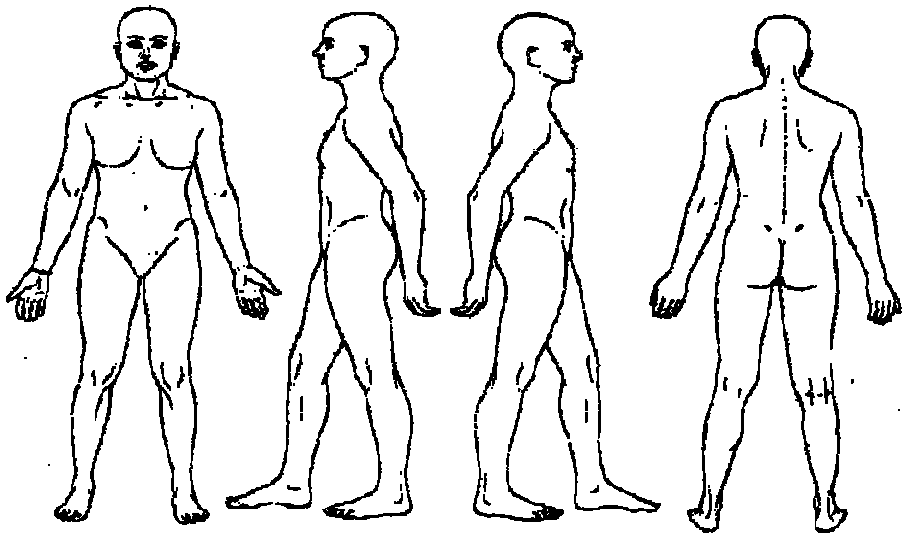
If yes, when was your last treatment? _____

What brings you in for your appointment today?

☐ Neck Pain ☐ Shoulder Pain ☐ Low Back Pain ☐ General Relaxation

☐ Other Please explain: _____

On the diagram below, please shade the areas that you would to have specific attention during your massage



Do you have allergies, skin sensitivities or asthmatic reactions? **Yes** **No**

☐ Plants/Trees/Flowers ☐ Nuts ☐ Oils/Lotions ☐ Other

Please explain: _____

PA Licensed Massage - General Health Questionnaire

Have you had any surgeries in the past 5 years? **Yes** **No**

Year	Surgery Performed
Year	Surgery Performed
Year	Surgery Performed
Year	Surgery Performed

Are you currently taking any medications? *please list below*

Do you have or have you had any of the following conditions? *check all that apply*

- ☐ Headaches, Migraines
- ☐ Asthma, Lung Conditions
- ☐ Muscle, Bone Injuries
- ☐ Arthritis
- ☐ Spine Disorders
- ☐ Stress, Tension
- ☐ Rashes, Athlete's Foot
- ☐ Vericose Veins
- ☐ Epilepsy, Seizures
- ☐ Sinus Problems
- ☐ Digestive Problems
- ☐ Numbness, Tingling
- ☐ Fibromyalgia
- ☐ Diabetes
- ☐ Depression
- ☐ Infectious Disease
- ☐ High Blood Pressure
- ☐ Osetoporosis
- ☐ Jaw Pain, TMJ
- ☐ Joint Pain
- ☐ Sprains/Strains
- ☐ Cancer, Tumors
- ☐ Heart, Circulatory Problems
- ☐ Sleep Problems
- ☐ Blood Clots
- ☐ Low Blood Pressure
- ☐ Pregnancy *(current)*

I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Care Physician for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease.
Because massage must not be performed under certain circumstances, I have made the therapist aware of my existing medical conditions. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.
If I experience any pain or discomfort during the session, I will immediately communicate it to the therapist so the treatment can be adjusted. If I have any questions about the therapy, I know that I am free to ask.
I have read a copy of the therapist's policies. I understand and agree to abide by them.

Signature _____ **Date** _____