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# Client Health Questionnaire

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Please print clearly. All information shared will remain confidential.

Today's Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Height \_\_\_\_\_  
City \_\_\_\_\_ Weight \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Occupation \_\_\_\_\_  
Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_  
Email \_\_\_\_\_  *Please don't add me to the mailing list*

Please mark "X" for conditions that apply now, and "P" for past conditions:

- |                          |                         |                          |
|--------------------------|-------------------------|--------------------------|
| ___ muscle/joint pain    | ___ diabetes            | ___ anxiety, stress      |
| ___ sprains, strains     | ___ osteoporosis        | ___ depression           |
| ___ arthritis/tendonitis | ___ convulsions         | ___ sleep difficulties   |
| ___ numbness, tingling   | ___ blood clots         | ___ allergies            |
| ___ cancer               | ___ varicose veins      | ___ circulatory problems |
| ___ asthma               | ___ blood pressure      | ___ respiratory problems |
| ___ digestive problems   | ___ infectious diseases | ___ hemophilia           |
| ___ athlete's foot       | ___ PMS                 | ___ birth control, IUD   |
| ___ skin conditions      | ___ fatigue             | ___ pregnancy            |

Please explain areas noted above: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you wear:  Contacts  Removable bridgework/dentures

Are you allergic or sensitive to:  Nuts  Fragrances

Surgeries: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Doctor, PT, or chiropractic care: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Current Medications:	For:	Since:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Sports, exercise, or other physical activities and frequency: \_\_\_\_\_

Hobbies and stress reduction activities: \_\_\_\_\_

Previous professional bodywork: \_\_\_\_\_

What did you particularly like? \_\_\_\_\_

What did you dislike? \_\_\_\_\_

**Primary goal(s) for today's session:** *(Please check all that apply)*

- Relaxation, stress relief     Relief of pain or tension     Injury rehabilitation
- General health maintenance     Improve movement & flexibility
- Increase body awareness     Specific condition \_\_\_\_\_

**Informed Consent for Massage Therapy Session**

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 Caregiver 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, and that the therapist will happily answer.

I have read a copy of the therapist's policies; I understand them and agree to abide by them.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_