MASSAGE THERAPY QUESTIONNAIRE

Name: _____ D.O.B._____ Phone:_____

(**Please Print Legibly**)

Do any of the following apply to you? (Circle All That Apply)

Emotional Changes	Headaches	Allergies	Heart Ailment*	Infectious Condition*
Cancer*	Diabetes*	Flu/Cold	Skin Disorder*	High Blood Pressure*
Phlebitis*	Acute Pain	Scoliosis	Chronic Pain	Osteoporosis
Edema*	Arthritis	Sports Injury	TMJ syndrome	Addictions/Abuse
Fever*	Bursitis	Chronic Fatigue*	Neuropathy	Other

Are you currently under a doctor's care for any medical condition? _____

Are you pregnant?*_____ If so, how many weeks? ____ (**Massage will not be performed before 14th week.**)

Are you presently taking any prescription medications? If so, please list. _____

_____

Have you ever broken bones or undergone surgery? If so, please describe. _____

_____

Please list your present symptoms and/or areas of pain or discomfort._____

_____

Please list any Autoimmune Diseases. _____

_____

In case of an emergency, please notify: Name: _____ Phone: _____

I have completed this form to the best of my knowledge. I understand that massage therapy services are designed to be a health aid and are in no way to take the place of a doctor's care when it is indicated. Information exchanged during my massage therapy session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my discretion.

City Spa is not responsible for the aggravation of conditions that were not disclosed to the therapist. Please inform your therapist immediately if you experience any discomfort (i.e. room temperature, pressure, technique, music, etc.) so that your experience with us is a positive one. City Spa is committed to professionalism. Inappropriate behavior of any kind will not be tolerated and will result in the immediate termination of the session with no return of funds.

Signature: _____Date:_____

(Parent/Guardian if under 18)

*Hot Stone Treatment is contraindicated for these conditions.