MASSAGE THERAPY QUESTIONAIRE

Name ____ Email _________________________

Phone _________________________ DOB _____________________ Age _______________

Address ________________________________ City ___________ State _____Zip _________

Emergency Contact ____________________________ Phone ___________________________

Referred by _________________________________ Occupation _________________________

HEALTH HISTORY: Do any of the following apply to you? (circle all that apply)

Cardiovascular

Congestive heart failure	Embolism	Heart Attack
Heart Disease	Hemophilia	High blood pressure*
Low blood pressure	Pacemaker	Phlebitis*
Poor circulation	Stroke	Thrombosis
Varicose veins	Family history	Heart ailment*

Head & Neck

Dizziness	Ear Problems	Headache
Hearing loss	Jaw pain (TMJ)	Migraines
Vision loss	Vision problems	Acute pain

Musculoskeletal

Arthritis	Artificial joint	Bursitis
Osteoporosis	Surgical pin/wire	Tendonitis
Scoliosis		

Neurological

Epilepsy	Multiple sclerosis	Numbness/tingling
Sensory loss/change	Sciatica	Seizures
Neuropathy		

Respiratory

Asthma	Bronchitis	Chronic cough
Emphysema	Shortness of breath	Sinusitis
Smoker	Tuberculosis	Family history

Reproductive

Given birth	Gynecological problems	Pregnant

Skin

Bruise easily	Skin conditions	Skin infections*
Skin irritations	Infectious condition*	

Miscellaneous

Anxiety	Cancer*	Depression
Diabetes*	Digestive conditions	Fibromyalgia
Stress	Edema*	Chronic fatigue*
Fever*	Chronic Pain	Allergies
Flu/Cold	Addictions/abuse	Emotional changes
Headaches	Other____	

****Hot stone treatment is contraindicated for these conditions****

Are you presently taking any prescription medications? If yes, please list ________________________

____

Any allergies? (oils, lotions, nuts, fruits, scents, etc.) If yes, please list

____

Are you pregnant*? If yes, how many weeks? ______________ (***Massage will not be performed before 14th week)***

Are you currently under a doctor's care for any medical condition? _________ If yes, please describe.

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Ares of broken skin? (e.g. rash, wounds) _____ If yes, where? _______________________________

History of joint replacement surgery? ______ If yes, which joint(s)? ____________________________

Recent injuries or medical procedures in the past 2 years? ________ Please describe. ________________

____

Have you had a professional massage before? __________ How recently? _______________________

Reason for seeking massage. _____ Relaxation _______Specific problem _________________________

How much pressure do you prefer? ____Light _____Medium ____Firm

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, intended to help me become more familiar and conscious of my own health status, and is to be used at my discretion.

Changes 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 temp., pressure, technique, music, etc.) so that your experience with us is a positive one. Changes 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 18yrs old)