



MASSAGE THERAPY QUESTIONNAIRE

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 irritations

Skin conditions

Infectious condition*

Skin infections*

Miscellaneous

Anxiety

Diabetes*

Stress

Fever*

Flu/Cold

Other _____

Cancer*

Digestive conditions

Edema*

Chronic Pain

Addictions/abuse

Depression

Fibromyalgia

Chronic fatigue*

Allergies

Emotional changes

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. _____

Areas 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)