INTEGRATIVE ORTHOPEDIC MASSAGE ~ YOGA ~ FITNESS

Massage Health Questionnaire

Name: _____ Today's Date: _____ DOB: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell: _____ Text OK? ❑ Yes ❑ No

Email: _____ May we add you to our email list? ❑ Yes ❑ No

Occupation: _____ Referred by: _____

Have you ever had a professional massage? ❑ Yes ❑ No If yes, how often? _____

What type of pressure do you prefer? ❑ Light ❑ Medium ❑ Firm ❑ Not sure

What is your goal for massage?

❑ **Relaxation/Wellness** (full body, general relaxation for stress/tension) **Monthly maintenance recommended**
Optional enhancements included; Hot Towels and Aromatherapy

❑ **Therapeutic/Orthopedic** (localized pain from minor injury, chronic conditions) **Treatment plan recommended**
Optional enhancements included; Hot Packs, Cupping or Gua Sha (scraping), and Hot/Cold Rock Sauce®
Therapeutic Taping add $10.00.

❑ **Injury/Rehabilitation** (personal injury, auto accident, surgery recovery) **Doctor prescription and treatment plan required**

Which of the following would you like to incorporate into your self-care program?

❑ Yoga / Stretching
❑ Breath Work / Meditation / Energy Work
❑ Corrective Exercise / Personal Training
❑ PLEASE invite me to join your Self-Care Group on Facebook

Check ✗ the regions where you are currently experiencing symptoms, then rate them in order of intensity (1= highest)

❑ #____ Head / Neck / Jaw ❑ #____ Shoulder / Upper Arm ❑ #____ Upper / Lower Back
❑ #____ Low Back / Hip ❑ #____ Knee / Thigh ❑ #____ Lower Leg / Ankle / Foot
❑ #____ Elbow / Forearm / Wrist / Hand

Describe your symptoms: _____

_____

Have you ever seen your physician for any of these conditions? ❑ Yes ❑ No

How long have you had it? _____

How often does it occur? _____

Is there any activity that makes it worse? _____

Are you currently on a routine exercise program? ❑ Yes ❑ No _____x's/wk

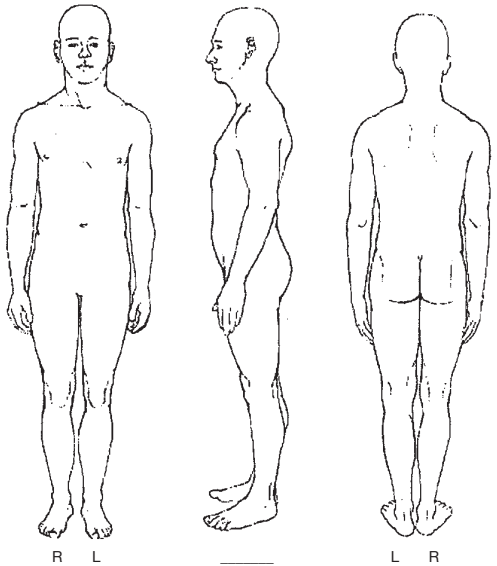
Check ✗ all the treatments have you tried.
Circle ❍ if the treatment made your symptoms feel better.

❑ Ice / Heat ❑ Medication ❑ Physical Therapy ❑ Chiropractic
❑ Stretching ❑ Exercise ❑ Trigger Point Injection / Cortisone Shots
❑ Dry Needling / Acupuncture ❑ Other: _____

On a scale from 1-10, 1=lowest, 10=highest, rate your levels of:

Stress _____ Pain _____ Energy _____

On the body diagram, please ❍ circle any areas where you carry tension and stress, put an "X" where you are experiencing pain and/or discomfort, put an arrow → if the pain radiates.



Please complete side 2 →

Medical Information

Carefully read the following health conditions and check all that apply to you. If you select ✗ yes, please provide a detailed explanation (use back side of paper if necessary). Under certain conditions a referral from your physician may be required.

Health Conditions	YES	NO	Please Explain / Be Specific
Allergies / Asthma / Emphysema (Respiratory)	Y	N	
Arthritis	☐	☐	
Cancer or Tumors	☐	☐	
Cardiovascular / Circulatory	☐	☐	Please circle all that apply: Anemia, Angina, Arteriosclerosis, Congestive Heart Failure, Blood Clots, Embolism/Thrombosis, Heart Attack, Heart Murmur, Hemophilia, High or Low Blood Pressure, Stroke, Varicose Veins, Lymph edema, Other:
Contact Lenses / Dentures / Prosthetics	☐	☐	
Diabetes	☐	☐	Type: _____
Difficulty Sleeping / Tired / Fatigued / Low Energy	☐	☐	
Depression / Anxiety / Post-Traumatic Stress	☐	☐	
Gastrointestinal Problems	☐	☐	
Infectious Conditions	☐	☐	Athlete's Foot, Hepatitis, Herpes, HIV, Infectious Respiratory, Infectious Skin Conditions, etc.
Injuries / Accidents	☐	☐	☐ Fully Recovered
Osteoporosis	☐	☐	
Women	☐	☐	Pregnancy or Gynecological Conditions
Medications (Please list all medications)			
Skin Conditions	☐	☐	Please circle all that apply: Acne, Abrasions/Cuts, Birthmarks/ Moles, Bruises, Dermatitis, Eczema, Herpes, Hives, Infections, Poison Ivy/Oak/Sumac, Psoriasis, Skin tags, Sunburns, Warts, Scars, Other:
Surgeries	☐	☐	☐ Fully Recovered Type: _____

Please explain here any other health related information to your therapist: (autoimmune conditions, neurological disorders, diagnosed diseases and other medical conditions)

_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: X _____ Date: _____

Therapist Signature: _____ Date: _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork, or therapeutic techniques to my child or dependent, _____, as they deem necessary based on the information provided on this form. I agree to be present during the intake and massage session, and ask questions on behalf of my minor child.

Signature of Parent or Guardian _____ Date _____

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