Wellstar Health Place

Massage Therapy Health History Questionnaire

Name:_____ Birthdate: _____

Address:_____

Phone (Home): _____Phone (Cell): _____

Email Address:_____

Emergency Contact:_____Phone:_____

Physician: _____Phone:_____

Referred by?_____Is this your first massage?_____

Occupation: _____

General Medical History

Check any current or past conditions and procedures.

- o Arthritis
- o Bursitis
- o Back pain
- o Neck pain
- o Arms/hands pain
- o Hips/legs/feet pain
- o Chest pain
- o Headaches/TMJ
- o Swollen joints
- o Fibromyalgia/edema
- o Sciatica/triggers
- o High blood pressure
- o Low blood pressure
- o Congenital heart disease
- o Irregular heartbeat
- o Heart murmur
- o Pacemaker/implanted defibrillator
- o Heart attack
- o Heart failure
- o Heart transplant
- o Heart conditions
- o Thyroid
- o Shortness of breath/dizziness
- o Stroke
- o Seizures/convulsions
- o Epilepsy
- o Sinus/allergies
- o Hematomas
- o Phlebitis
- o Varicose veins
- o Warts/athletes foot
- o Down syndrome

- o Osteoporosis
- o Scoliosis
- o Herniated disk
- o Degenerative disk
- o Spinal cord injury
- o Knee replacement
- o Rotator cuff replacement
- o Hip replacement
- o Constipation
- o Painful urination
- o Kidney disease
- o Peripheral vascular or arterial disease-affecting the blood
- o Poor circulation/LRM (limited range of motion)
- o Anemia
- o Menstrual pain
- o Mastectomy: Type:_____
- o Hysterectomy
- o Pregnant? ____#months

- o Diabetes: Type: _____
- o Cancer: Type:_____
- o Skin conditions: Type:_____
- o Epidural: if yes, list when:_____

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Have you recently had a car accident/injury? _____

Have you had any recent surgery? Type:_____ When?_____

Do you have any other medical conditions that I should be aware of?_____

Where do you carry your stress and tension?_____

Do you wear contacts/hearing aids/glasses?_____

Do you have any allergies? If yes, List:_____

Describe exercise activities that you do. Include frequency:_____

Are you sensitive to touch/pressure in any areas? _____

What type of pressure do you like?_____

What is your goal in the session today?_____

Please list any additional comments regarding your health and well being if needed.

_____

Do you have any special accommodations/needs? _____

Medications

List prescriptions and over-the-counter medications:

_____ _____

_____ _____

_____ _____

I understand if I experience any pain or discomfort during my massage, I will immediately inform the massage/ stretch professional, so that the pressure and / or strokes may be adjusted to my level of comfort. I understand that massage should not be considered a substitute for medical examination, diagnosis, or treatment, chair massage is also recognized as a medical accommodation and can be recommended by a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment I am aware of. I understand, any inappropriate comments or behaviors will result in my session being terminated immediately. Massage is contraindicated under certain medical conditions. I acknowledge that I have read this questionnaire in its entirety and responded accurately to the best of my knowledge. If my health status changes, I understand that I am responsible for informing my massage/ stretch professional.

Signature:_____Printed Name: _____ Date: _____