Lily Health SPA

2378 Highway 94 South Outer Road
St. Charles, MO 63303

Personal Health Questionnaire

When you can't change the world, you can learn to change your response to it...

Today's Date: _____ Date of Birth: _____

Name : _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (home): _____ Work: _____

Email : _____

Age: _____ Sex: _____ Profession: _____

How did you find us (circle as many as apply)?

_____

Name of person who referred you & e-mail/phone_____

Medications: _____

Allergies: _____ Allergy to any oils: _____

Are you pregnant? _____ Due date: _____

Do you wear contacts? _____ A pacemaker? _____

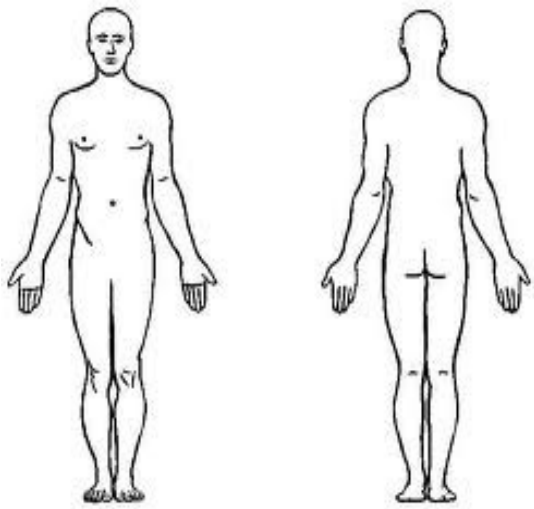
Please detail any recent surgeries: _____

Reason(s) for massage: _____

Areas to Avoid (Please Check Mark): ☐Stomach ☐Glutes ☐Other:_____

Do you have stress in your daily life? Yes or No Where is it held in body?_____

Check those areas where are having difficulty	
	AIDS/HIV
	Allergies
	Aortic Aneurysm
	Arteriosclerosis
	Cancer
	Cervical Spine Problems
	Diarrhea
	Fractures
	Heart Disease
	Hernia
	High Blood Pressure
	Joint Problems
	Menstruation
	Open Wounds and Cuts
	Osteoporosis
	Phlebitis(DVT)
	Previous Dislocation
	Pregnancy, due date:
	Rheumatoid Arthritis
	Skin Disease
	Stroke
	Surgery
	Other (identify):



Please circle your problem areas on the drawing.

Consent for Massage

It is understood that the purpose of a massage is of relaxation and that it is not meant to diagnose or treat any illness, or any other physical or mental disorder, injury, or condition.
I have informed my therapist about my state of health and I have transmitted to him or her any recommendations and/or restrictions on the part of my medical doctor or therapist insofar as massage.

Client's signature: _____Date:_____