**Catawba Springs Massage**

**Health History Questionnaire**

All questions contained in this questionnaire are strictly confidential and will become part of your medical file

**Date:**

|  |  |
| --- | --- |
| **Name** | **DOB: Age:** |
| **Marital Status:** | □ Male □ Female |
| **Referring Doctor:** | **Chiropractor:** |
| **Address:** | **City: State: Zip:** |
| **Email:** | **Cell:** |
| **Emergency Contact:** | **How did you hear of us?** |
| **Occupation:** | **Previous Massages? NMT experience?** |
| **Major Complaints?** | **Minor Complaints?** |

|  |  |
| --- | --- |
| List Medical problems and diagnosis: |  |
| List Surgeries and hospitalizations: |  |
| List Medications: Prescribed and over the counter. |  |
| List allergies: |  |
| Any other health concerns? |  |
| Bruises? Broken skin? Lumps? Bumps? Rashes? |  |
| List leisure activities, exercise and stress relievers? |  |

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| **Pregnancy? Y N Trimester? Contact Lens? Y N Hearing Aids? Y N Dentures? Y N** |

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| **Difficulty lying on back? Y N Stomach? Y N Trouble sleeping? Y N** |