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?	

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

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