CONFIDENTIAL QUESTIONNAIRE

This questionaire has been designed to help me provide the best professional, specialized care and service to you. The information you provide will be held in strict confidence to protect your privacy.

Name ______________________________ Birthday ______________

Address ______________________ City ______________________ State ________ Zip ____________

Cell ______________________ Email ______________________________

Occupation ______________________________ Employer ______________________________

Have You Had a Professional Massage Before? ____________ **Referred By** ______________________________

REASON FOR TODAY'S VISIT ______________________________

PREFERRED DEPTH OF PRESSURE: ☐ **Light** *(Relaxing)* ☐ **Medium** *(Purposeful)* ☐ **Deep** *(Therapeutic)*

MEDICAL HISTORY *(Check, Circle or List All that Apply)*

- ☐ Allergies ______________________
- ☐ Arthritis / Bursitis ______________
- ☐ Artificial Joints / Implants / Pins / Rods ______________________
- ☐ Asthma / COPD
- ☐ Back / Spine Conditions
- ☐ Blood Clots *(Located?)* ____________
- ☐ Blood Pressure *(High / Low)*
- ☐ Bruise Easily
- ☐ Chiropratic Care *(Dr.)* ____________
- ☐ Diabetes *(Type I or Type II)*
- ☐ Flu Shot *(Within Last 48 hours?)* ________
- ☐ Headaches *(How Often?)* ______________________
- ☐ Hearing Aid(s)
- ☐ Heart / Circulatory Condition
- ☐ Joint Issues *(Located?)* ____________
- ☐ Low Back Pain
- ☐ Physical Therapist *(Reason? How Often?)* ______________________
- ☐ Pregnant *(# of Weeks and Due Date)* ______________________
- ☐ Recent Surgeries *(Within the last year)* ______________________
- ☐ Sciatic Nerve Pain
- ☐ Seizures / Epilepsy / Brain Injuries
- ☐ Skin Conditions / Sensitivities ______________________
- ☐ Stress / Anxiety
- ☐ TMJ / Teeth Clenching / Grinding
- ☐ Varicose Veins
- ☐ Other ______________________
- ☐ Please list any ***major*** medications you are currently taking ____________ ______________________

I understand that certain medical conditions or symptoms may contraindicate massage/bodywork. In some cases a referral from my primary care provider may be required before services can be provided. By signing below, I affirm that I have disclosed all my known medical conditions and answered all questions thoroughly and honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that my failure to do so releases the therapist from any liability. I further understand that massage/bodywork acts on the tissues of the body and cannot substitute for the examination, diagnosis or treatment by a medical doctor, chiropractor, mental health professional, or other qualified practitioner. ***Finally, I understand that I am responsible for communicating to the therapist any adjustments to pressure, technique or body region necessary to maintain my level of comfort.*** THIS IS A PROFESSIONAL MASSAGE SETTING; 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.

Emergency Contact ______________________ Relationship ____________ Phone ______________

Signature ______________________________ **Date** ______________