Client Questionnaire

In order to maximize the effectiveness and safety of our session together, we ask that you take the time to fill out this *confidential* questionnaire carefully.

Date:________________ Referred by:_________________

Name:____

Would you like to receive our e-mail newsletter? E-mail:________________________________

Address:________________________City:_____________________State:____Zip:_________

Phone: (day) _________________ (eve)________________ Occupation: ________________

Date of Birth:___________________ Height: ________________
Weight:________________
Build: ______________________

Have you had any previous experience with professional massage? __ Yes __ No

If yes, please briefly describe: ____

What are your daily activities/ sports/ hobbies:____

____

Do you:

__ Exercise __ Use tobacco __ Drink Alcohol __ Smoke __ Consume Caffeine

Posture assumed most of the day: _________________ Sleep habits: ______________________
Bowels: ___________________

Please list any prescription drugs, herbal remedies, and over the counter medications you are presently using: ____

Medical History: Please indicate any significant medical problems or conditions that may influence the type and/ or depth of work doneA00865
in any given area.

__ Skin condition (acne, rash, skin cancer, other):_____________________________________
__ Allergies: ____
__ Lymphatic Condition (swollen glands, lymphoma, lymphedema, other):_________________
__ Circulatory condition (heart disease, varicose veins, phlebitis, arrhythmia, arteriosclerosis):
____

__ Neurological condition (sciatica, numbness/tingling of any area of the skin, stroke, epilepsy,

other):____

__ Bone Conditions (osteoporosis, previous fracture cancer, other):____________________

__ Headaches (migraines, PMS, tension, cluster, other):__________________________

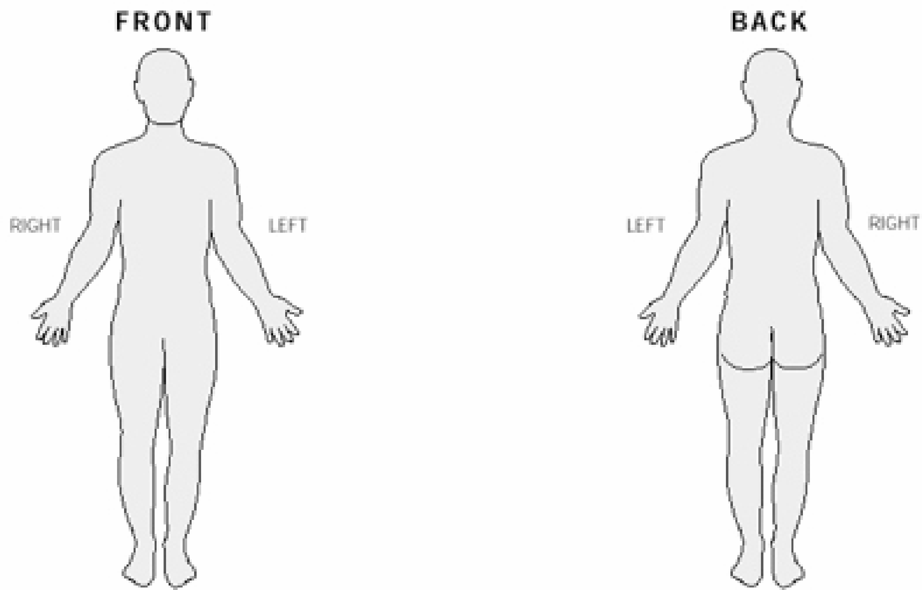
__ Emotional difficulties (depression, anxiety, psychotic episodes, other): ______________

__ Stress

__ Previous Surgery (if yes, please state type and date):
____

__ Any other medical
considerations:______________________________________

Please show any significant problem areas or recent injuries on the diagram below:



Name of Primary Physician: ____________________ Phone: __________________

Do we have permission to contact him/her should the need arise? __ Yes __ No

Health History

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

__ Headaches
__ Joint stiffness/swelling
__ Spasms/Cramps
__ Broken/Fractured bones
__ Strains/Sprains
__ Back/Hip pain
__ Shoulder, neck, arm, hand pain
__ Leg, foot pain
__ Chest, ribs abdominal pain
__ Problems, walking
__ Jaw pain, TMJ
__ Tendinitis
__ Bursitis
__ Arthritis
__ Osteoporosis
__ Scoliosis
__ Bone or joint disease
__ Other:___________

Circulatory and Respiratory

__ Dizziness
__ Shortness of Breath
__ Fainting
__ Cold feet or hands
__ Swollen glands
__ Pressure sores
__ Varicose Veins
__ Blood clots
__ Stroke
__ Heart Condition
__ Allergies
__ Asthma
__ High blood pressure
__ Low blood pressure
__ Lymphedema

Skin

__ Rashes
__ Allergies
__ Athletes Foot
__ Warts
__ Moles
__ Acne
__ Cosmetic Surgery

Digestive

__ Nervous stomach
__ Indigestion
__ Constipation
__ Intestinal gas/bleeding
__ Diarrhea
__ Diverticulitis
__ Irritable Bowel Syndrome
__ Crohn=s Disease
__ Adaptive aids
__ Other:_____________

Nervous System

__ Numbness/tingling
__ Twitching of face
__ Fatigue
__ Chronic pain
__ Sleep disorders
__ Ulcers
__ Paralysis
__ Herpes/Shingles
__ Cerebral Palsy
__ Epilepsy
__ Chronic Fatigue Syndrome
__ Multiple Sclerosis
__ Parkinson=s Disease
__ Spinal Chord Injury
__ Other:_____________

Reproductive System

__ Pregnancy:
__current __ previous
__ PMS
__ Menopause
__ Pelvic Inflammatory Disease
__ Endometriosis
__ Hysterectomy
__ Fertility concerns
__ Prostate problems

Other

__ Loss of appetite
__ Forgetfulness
__ Confusion
__ Depression
__ Difficulty concentrating
__ Drug use___________
__ Alcohol use ________
__ Nicotine use________
__ Caffeine use________
__ Hearing Impaired
__ Visually impaired
__ Burning upon urination
__ Bladder Infection
__ Eating Disorder
__ Diabetes
__ Fibromyalgia
__ Post/Polio Syndrome
__ Cancer
__ Infectious Disease (Please list)_________
____
__ Other congenial or Acquired disabilities

(please list)________ __ Surgeries__________ __ Other_____________

For clients who need mobility assistance, please give your height:_________ weight:_________

Please list any additional comments regarding your health and well-being: __________________
____

I have stated all condition that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

****

Client understands that the practitioner is neither trained nor licensed to provide medical treatment, to diagnose, prescribe drugs or medicines, perform spinal or other joint manipulations, or any service in which a licensed to practice medicine, chiropractic, naturopathy, physical therapy, or podiatry is required by law.

The practitioner makes no claims, representations or guarantees about specific results.

Client has been provided with descriptions of the service and anticipated benefits. Client understands and agrees to the purpose, nature, and duration of the proposed service and consents to receive this service.

Client understands that there can be remote risks associated with this work. Client acknowledges and agrees to indemnify the practitioner and hold him/her harmless from any injury arising because of an unreported condition and/or concern.

Client agrees and acknowledges the opportunity to ask questions before receiving any work and to question or interrupt the work at any point after the session begins.

Client has read and understood this document and agrees to the above by signing and dating below.

Signature: _________________________________ Date: _______________________