CONFIDENTIAL QUESTIONNAIRE FOR MASSAGE

Date _____ How did you learn about us? _____

Last Name _____ First Name _____ M.I. _____

Street Address _____ City _____ Zip _____

Phone: Hm _____ Wk _____ Cell _____

Date of Birth _____ Age _____ Sex: ☐F ☐M Marital Status: ☐S ☐M ☐D

SS# _____ Driver's License _____

Occupation/Activities _____

Injury Treatment? ☐Yes ☐No Date of Injury _____ ☐Auto ☐Work ☐Other

Name of Referring Physician _____ Phone# _____

Your Insurance Information

Type of Insurance: ☐Auto ☐Health ☐L&I/Workers' Comp

Name of **Primary Insured** _____ **D. of B.** _____ SS# ___-___-____

Relationship to insured: ☐Self ☐Spouse ☐Child Insurance Co. _____

Claim# _____ Claims Adjuster _____ Phone# _____

Address _____ City _____ State ____ Zip _____

Insured's Employer _____ ☐Full Time ☐Part Time

Address _____ City _____ State ____ Zip _____

Please Read and Sign the Following

I acknowledge that the above information is complete and accurate to the best of my knowledge and I will notify the treating Massage Therapist of any changes in my physical condition prior to treatment or any changes in the information as presented on this form.

I agree to the release of information for medical and/or insurance purposes and authorize the treating Massage Therapist to obtain any information from my healthcare providers concerning my health.

I am aware, that I am fully responsible for all health care bills for services rendered and that payment is not contingent on any settlement, judgment or insurance payment. An unpaid balance is due 30 days from invoice date. A $15.00 re-billing fee plus 1% interest will be charged each month until balance due is paid. Each bank returned check will be charged $15.00. Additional court, attorney or collection agency fees may be charged if applicable.

Time change, missed appointment or cancellation with less than 24 hours notice will be charged ½ of the scheduled massage fee.

Guardian or
Client Signature: _____ Date: _____

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HEALTH HISTORY

Patient Name _____

Have you ever experienced any of the following? Please use '**C**' for current, '**P**' for past, '**S**' for sometimes

__ HIV/AIDS	__ Constipation	__ Herpes	__ Sciatica
__ Allergies	__ Diarrhea	__ High Blood Pressure	__ Stiff Joints
__ Anemia	__ Diabetes	__ Low Blood Pressure	__ Skin Allergies
__ Athletes Foot	__ Digestive Problems	__ Insomnia	__ Sprains/Strains
__ Arthritis	__ Disc Problems	__ Excess Stress	__ Stroke
__ Back Pain	__ Diverticulitis	__ Migraines	__ Swollen Feet/Legs
__ Bone Fractures	__ Eczema	__ Muscle Spasms	__ Tendonitis
__ Bursitis	__ Epilepsy/Seizures	__ Numbness	__ Tingling
__ Cancer	__ Fibromyalgia	__ Phlebitis	__ Tumors
__ Chronic Fatigue	__ Headaches	__ Psoriasis	__ Varicose Veins
__ Circulatory Problems	__ Heart Attack/Ailments	__ Rashes	__ Whiplash
__ Colitis	__ Hemophilia	__ Ringworm	__ Other _____

For Women only:

__ Pregnant	__ Trying to be Pregnant	__ Menstrual Cramps	__ PMS
__ Excessive Bleeding	__ Amenorrhea		

Accidents, Injuries or Surgeries:

Less than 5 years ago _____

More than 5 years ago _____

Are you currently receiving medical or chiropractic care? ☐ Yes ☐ No

If yes, please explain _____

Are you taking any medications (prescription & over-the-counter)? ☐ Yes ☐ No

If yes, please explain _____

Do you wear hard contacts? ☐ Yes ☐ No

Habits	Heavy	Moderate	Light	None
Tobacco	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Exercise	_____	_____	_____	_____

What type of exercise? _____ How often? _____

Have you received massage before? ☐ Yes ☐ No

What did you especially like or dislike? _____

_____

Why have you come for massage? _____

_____

Guardian or Client Signature: _____ **Date:** _____

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CONFIDENTIAL QUESTIONNAIRE FOR MASSAGE

PATIENT PRESENT COMPLAINTS

Name: _____

Please describe your current problem: _____

_____

_____

How did the problem begin? _____

_____ Date it began: _____

What makes it better? _____

What makes it worse? _____

Any range of motion restrictions? _____

What treatment(s) have you had for this condition? _____

_____

How bad is your pain?	1	2	3	4	5	6	7	8	9	10
	No pain									Unbearable pain

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Describe your current pain/symptoms: ☐ Shooting ☐ Throbbing ☐ Dull ☐ Sharp/Stabbing ☐ Burning ☐ Numbness ☐ Soreness ☐ Tingling

Can you perform your daily ***home*** activities ☐ w/out pain ☐ w/pain - Explain _____

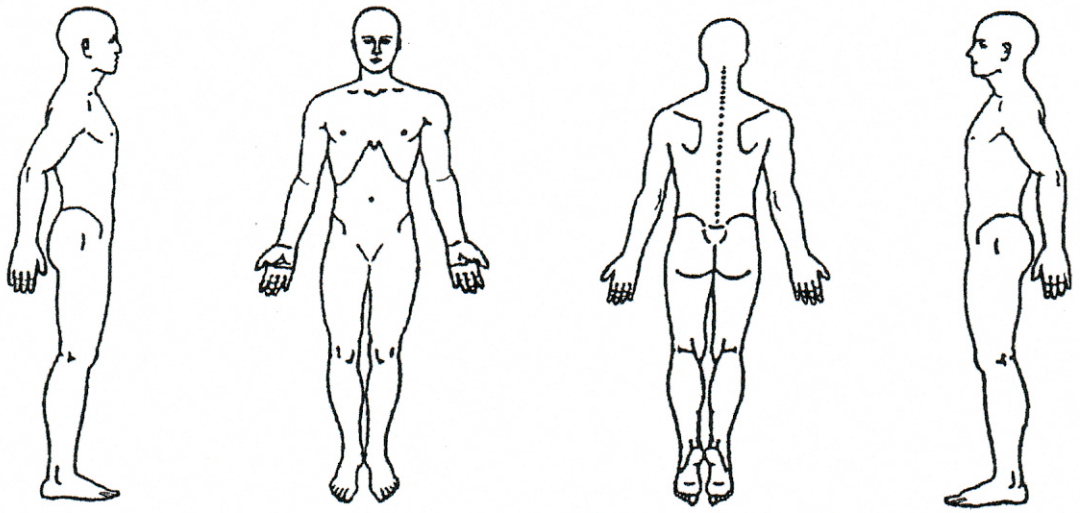
Can you perform your daily ***work*** activities ☐ w/out pain ☐ w/pain - Explain _____

How is the quality of your sleep? _____ Hours of sleep lost _____

What are your goals with massage therapy? _____

Mark on the pictures where you have symptoms of pain, numbness or tingling

Circle areas you do not want to be touched



Guardian or Client Signature: _____ **Date:** _____