Massage Therapy Health History Questionnaire

Name: _____ Date of Birth: _____
First Last Middle

Member: _____ Non-Member: _____

Adress: _____

City: _____ State: _____ Zip: _____

Home Phone:_____ Cell Phone:_____

Emergency Contact: Name:_____ Relationship:_____

Phone Number:_____

Do you wear Contacts:_____Hearing Aids:_____

In the last year have you:

Had an operation? _____Please describe:_____

Broken any bones?_____Please describe:_____

List any medications that you are currently taking:_____

_____

Doctor's name and phone #:_____

Please check of you have, or have ever had, any of the following in the last three years:

- ☐ Abdominal Pain
- ☐ AIDS
- ☐ Arthritis
- ☐ Cancer
- ☐ Chronic Fatigue
- ☐ Colitis
- ☐ Diabetes
- ☐ Dizziness
- ☐ Pleurisy
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Migraines
- ☐ Painful Urination
- ☐ Phlebitis
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shortness of Breath
- ☐ Skin Irritations
- ☐ Thyroid
- ☐ TMJ Dysfunction
- ☐ Varicose Veins
- ☐ Other

If other, please explain: _____

Are you Pregnant?_____ How many months?_____ Using Midwife?_____

Obstetrician's name and Phone #:_____

Signature:_____**Date:**_____

Referred by:_____