Wellstar
Health Place

Massage Therapy
Health History Questionnaire

Name:_____ Birthdate: _____

Address:_____

Phone (Home): _____Phone (Cell): _____

Email Address:_____

Emergency Contact:_____Phone:_____

Physician: _____Phone:_____

Referred by?_____Is this your first massage?_____

Occupation: _____

General Medical History

Check any current or past conditions and procedures.

- o Arthritis
- o Bursitis
- o Back pain
- o Neck pain
- o Arms/hands pain
- o Hips/legs/feet pain
- o Chest pain
- o Headaches/TMJ
- o Swollen joints
- o Fibromyalgia/edema
- o Sciatica/triggers
- o High blood pressure
- o Low blood pressure
- o Congenital heart disease
- o Irregular heartbeat
- o Heart murmur
- o Pacemaker/implanted defibrillator
- o Heart attack
- o Heart failure
- o Heart transplant
- o Heart conditions
- o Thyroid
- o Shortness of breath/dizziness
- o Stroke
- o Seizures/convulsions
- o Epilepsy
- o Sinus/allergies
- o Hematomas
- o Phlebitis
- o Varicose veins
- o Warts/athletes foot
- o Down syndrome

- o Osteoporosis
- o Scoliosis
- o Herniated disk
- o Degenerative disk
- o Spinal cord injury
- o Knee replacement
- o Rotator cuff replacement
- o Hip replacement
- o Constipation
- o Painful urination
- o Kidney disease
- o Peripheral vascular or arterial disease-affecting the blood
- o Poor circulation/LRM (limited range of motion)
- o Anemia
- o Diabetes: Type: _____
- o Cancer: Type:_____
- o Skin conditions: Type:_____
- o Epidural: if yes, list when:____
- o Menstrual pain
- o Mastectomy: Type:_____
- o Hysterectomy
- o Pregnant? ____#months

Wellstar Health Place

Massage Therapy Health History Questionnaire

Have you recently had a car accident/injury? _____

Have you had any recent surgery? Type:_____ When?_____

Do you have any other medical conditions that I should be aware of?_____

Where do you carry your stress and tension?_____

Do you wear contacts/hearing aids/glasses?_____

Do you have any allergies? If yes, List:_____

Describe exercise activities that you do. Include frequency:_____

Are you sensitive to touch/pressure in any areas? _____

What type of pressure do you like?_____

What is your goal in the session today?_____

Please list any additional comments regarding your health and well being if needed.

_____

Do you have any special accommodations/needs? _____

Medications

List prescriptions and over-the-counter medications:

_____ _____ _____

_____ _____ _____

I understand if I experience any pain or discomfort during my massage, I will immediately inform the massage therapist, so that the pressure and / or strokes may be adjusted to my level of comfort. I understand that massage should not be considered a substitute for medical examination, diagnosis, or treatment, chair massage is also recognized as a medical accommodation and can be recommended by a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment I am aware of. I understand, any inappropriate comments or behaviors will result in my session being terminated immediately. Massage is contraindicated under certain medical conditions. I acknowledge that I have read this questionnaire in its entirety and responded accurately to the best of my knowledge. If my health status changes, I understand that I am responsible for informing my massage therapist. My consent is informed and voluntary and I understand that I may withdraw my consent at any time except for actions already taken. I hereby release and hold harmless Wellstar Health System, Inc. and its affiliated entities including, but not limited to, Wellstar Health Place, from any and all claims arising from or related to the services provided in connection with the execution of this consent form.

Signature:_____Printed Name: _____ Date: _____