Massage Therapy Client Questionnaire

personal information

Name _____ Phone _____ Email _____

Address _____ Date of Birth ___/___/_____

The following information will be used to help plan safe and effective massage therapy sessions. Please answer the questions to the best of your knowledge

Date of initial visit ___/___/____

1. Have you had a professional massage before ? Yes No
   If yes, how often do you receive massage therapy ? _____

2. Do you have any difficulty lying in your front, back or side ? Yes No
   If yes, please explain _____

3. Do you have any allergies to oils, lotions or ointments ? Yes No
   If yes, please explain _____

4. Do you have sensitive skin ? Yes No

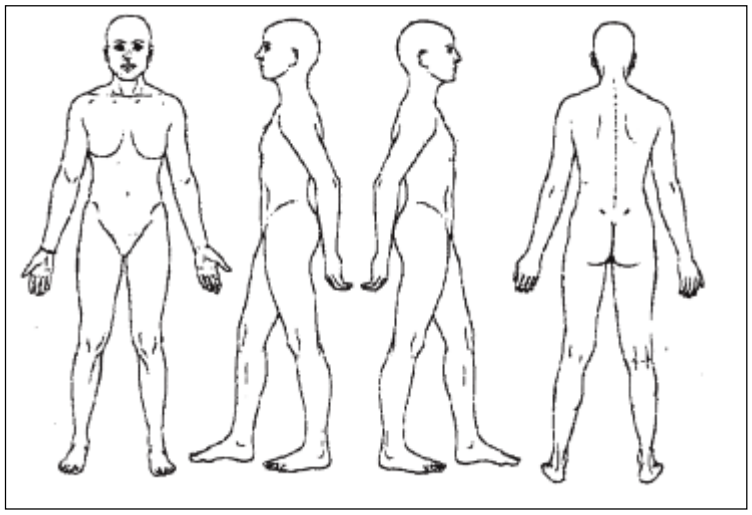
5. Do you sit for long hourse at a workstation, computer of driving ? Yes No
   If yes, please describe _____

6. Do you perform any repetitive movement in your work, sports or hobby ?
   If yes, please describe _____

7. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort ?
   If yes, please explain _____

8. Do you have any particular goals in mind for this massage session ? Yes No
   If yes, please explain _____

Circle any specific areas you would like the massage therapist to concentrate on during the session



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medical history

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

9. Are you currently under medical supervision ? Yes No
   If yes, please explain _____
10. Are you seeing an osteopath or chiropractor ? Yes No
   If yes, how often ? _____

11. Are you currently taking any medication ? Yes No
   If yes, please list _____

12. Please check/tick any condition listed below that applies to you :

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains / strains
( ) current fever
( ) swollen glands
( ) allergies / sensitivities
( ) heart condition
( ) high / low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) artheroscierosis
( ) phlebitis
( ) deep vain thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) osteoporosis
( ) epilepsy
( ) headaches / migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) fibromyalgia
( ) TMJ (Temporomandibular joint dysfunction)
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy, if yes how many months ?

Please explain any condition that you have marked above

_____

_____

_____

13. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you ? _____

_____

_____

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. Massage therapy does not diagnose illness or disease is not a substitute for medical examination, diagnosis or treatment. I understand that it is my choice to receive massage therapy and I am aware of the benefits and risks of massage and give my consent for massage. I have also stated all my known physical & medical conditions and will keep the massage therapist updated as to any changes.

Signature of client : _____ Date ___/___/_____

Signature of massage therapist : _____ Date ___/___/_____