Massage Therapy Questionnaire

Massage Therapist: Robin Streit

All information is strictly confidential and is intended to help you.

General Information	Date:	
Name:	Sex:	Age:
Address:	Height:	Weight:
	Email:	
Home Phone: Work Phone:	Cell:	
Emergency Contact Name:	Contact Phone:	
Doctor's Name:	Doctor's Phone:	

Occupation:	Have you ever had a massage before? Yes No
How did you hear of us?	If so, what type of pressure do you prefer?
For a referral: Do we have your permission to thank this person for referring you? Yes No	How long ago was your last massage?
Have you ever been injured? **Car Job Accident**	What are you looking to get from massage? Circle all that apply **Stress Reduction** **Injury Rehabilitation** **Pain Management** **Relaxation**
How long ago was the injury?	
Area of Injury?	List any part of your body that you do **not** want massaged:

Medical History: Check all that apply

___ If Female: Pregnant	___ Carpal Tunnel Syndrome	___ Arthritis
___ Chronic Headaches	___ TMJ	___ Numbness / tingling
___ Allergies (hay fever, pollen, etc…)	___ Chronic fatigue	___ Varicose veins / blood clots
___ Sinus problems	___ Digestive issues	___ Inflammation / swelling
___ Nausea	___ High cholesterol	___ Muscle cramping
___ Fainting / dizziness	___ Low blood pressure	___ Recent muscle trauma
___ Asthma	___ High blood pressure	___ Lyme disease
___ Diabetes	___ Heart problems	___ Contagious Disease
___ Skin trouble / skin allergies	___ Easily bruise	Explain: _____
___ Contacts / dentures	___ Osteoporosis	___ Cancer – type: _____
___ Epilepsy or Seizures	___ Stress Level (High, Medium, Low)	

Other (please specify):_____

_____

Allergies: Please list foods, drugs, oils, nuts, lotions, essential oils, or other known allergens: _____

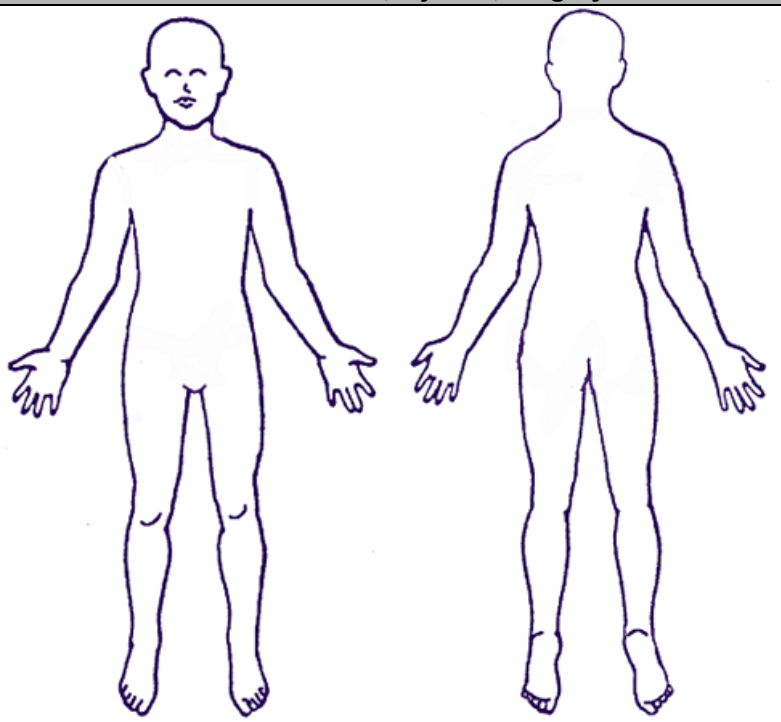
_____

Please list any prior surgeries:_____

Medications & Supplements

Name of Prescription or Supplement	***Condition***	***Name of Prescription or Supplement***	***Condition***

"O" (circle) locations that are in particular discomfort
"X" locations of broken bones, injuries, surgery



Please notify us at anytime if:

- Room temperature is too cold or warm.
- The massage is hurting you in any way.
- You would like additional massage in a particular area that needs attention.
- If you feel faint or ill.
- The music is not to your liking, or is too loud or too soft.
- The massage touch is too deep or not deep enough.
- If any technique is or is not to your liking.
- If you would like us to stop the massage.
- If you have any other special needs or requests.

Rules and Policies to help make your Massage more pleasurable:

- Please notify this office 24 hours in advance of any cancellation of your appointment.
- Promptly notify us of any injuries or changes in your health issues when making your appointment.
- Any client under the age of 18 must be accompanied by a parent or legal guardian.
- All notes, questionnaires, conversations, and client information will be kept strictly confidential.
- We encourage you to shower or wash for hygienic reasons prior to your massage.
- Your privacy will be respected at all times with proper draping. Please help us maintain propriety during your massage.
- Please refrain from wearing perfumes or jewelry when coming for a massage.
- Please turn off all electronic devices inside the office or treatment room.
- Payment is due at the time of the massage unless other arrangements have been made in advance.

I understand that massage therapy is for the purpose of stress reduction, relief from muscular discomfort and for increasing blood, lymph and energy circulation. I further understand the massage therapist does not diagnose illness, disease, or any other physical disorder. As such, the massage therapist does not prescribe medical treatment, medication(s) and does not perform spinal manipulation. By signing below, I further agree that I will not hold the massage therapist or its affiliates responsible should there be any unfavorable outcome or result. I have filled out this questionnaire and stated all my known medical conditions. I will keep the massage therapist updated on my physical health.

Client Signature: _____ ***Date:*** _____

Consent to Treatment of Minor: by my signature below, I hereby authorize the massage therapist to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ ***Date:*** _____

Intake Notes: