

Health Questionnaire for Massage Therapy

This form to be completed and brought in prior to receiving massage at SkinLife By Lesa.

Contact Information

Name : _____
Last First

D.O. B _____ / ____ / _____ (MM / DD / YYYY)

Occupation : _____

Home Address : _____
City State : _____ Zip : _____

Cell Phone # : _____ Email : _____

Home Phone # : _____ Business # : _____

The best way to contact me is : _____

Referred by : _____

Emergency Contact : _____ Phone : _____

Do you have any particular goals in mind for this massage session? _____

Have you ever had a professional massage before? Yes () No ()

Prohibiting Factors

Do you have any difficulty lying on your front, back or side? Yes () No ()

If yes, please explain : _____

Do you have sensitive skin? Yes () No ()

Any known allergies and or sensitivities to topical applications? Yes () No ()

If yes, please explain : _____

Are you wearing any of the following? contact lenses () dentures () a hearing aid ()

Do you sit for long hours at a workstation, computer or driving? Yes () No ()

Do you perform any repetitive movement in your work, sports or Hobby? Yes () No ()

If yes, please explain : _____

Pertinent Medical Information

Do you have or have you had any of the following conditions? Check appropriate lines.

- | | | |
|--|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Recent Surgery |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Whiplash | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Serious Accident | <input type="checkbox"/> Recent Fever |
| <input type="checkbox"/> Nervous Condition | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Any Contagious Disease | <input type="checkbox"/> Inflammation |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Internal Organ Dysfunction | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV virus | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Skin Disorders | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Decreased ROM | <input type="checkbox"/> Allergies | <input type="checkbox"/> Other |

Any further comments, explanations or information regarding your health history that would be useful for your massage therapist to know? _____

Are you presently under the care of a physician? Yes () No ()

If yes, please explain : _____

Are you taking any medications? Yes () No ()

If so please list medications you are taking and what they are prescribed for? _____

Are you presently under the guidance of a coach or certified athletic trainer? Yes () No ()

Do you participate in any of the following ?

Activity	Frequency (times per week)
___ Walking/jogging	_____
___ Running	_____
___ Swimming	_____
___ Aerobics/weight training	_____
___ Bicycling	_____
___ Racquet Sports	_____
___ Other _____	_____

Massage Information

When was your last massage? _____

Was there any part of the massage service you were NOT pleased with ? _____

Was there any part of the massage you especially liked? _____

The level of stress you feel today is : Low () Medium () High ()

How has stress affected your health?

Muscle tension () Anxiety () Insomnia () Irritability () Other _____

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort ? Yes () No ()

If yes, please identify : _____

Any other comments/requests you would like to add with regards to receiving your massage today?

POLICIES

Draping will be used during the session. Only the area being worked will be uncovered.

a.) I understand that : 24 hours notice is required for cancellation of an appointment, and that a fee of 50% of the cost of the scheduled service will be charged to me when this courtesy is not provided.

Initial _____ Date _____

b.) I understand that : I am to arrive 10 min before my scheduled appointment. (This prevents any stress in scheduling to you or the therapist, have a fresh beverage, use the facilities, turn off your cell phone-relax before your session!) You are here to relax and recover.

Initial ____ Date _____

c.) I understand that : I am to notify my massage therapist of any changes in my health care/Medical History

Initial ____ Date : _____

Massage increases circulation of lymph, blood and oxygen. It has been shown to greatly reduce stress, tension and pain. Massage can aid in better mood, increased energy and induce a more restful nights sleep. If you are seeking a massage for any other purpose such as a chronic pain condition, please list the conditions for which you wish to seek massage therapy :

I, _____ (print your name), understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical adjustments, diagnose, prescribe or treat any physical or mental illness. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there is no liability on the therapist's part should I fail to do so. In the event that I become injured either directly or indirectly as a result, in whole or in part of the aforesaid massage therapist I HEREBY HOLD HARMLESS AND INDEMNIFY the therapist and her principals and agents from all claims and liability whatsoever.

Signature : _____ Date : _____
 Massage Client

Signature : _____ Date : _____
 Massage Therapist

Pregnancy Massage Information and Informed Consent

Massage during pregnancy provides many benefits. It enhances circulation, supporting the work of your heart, and increasing the oxygen and nutrients delivered to your baby. It can relieve the sensation of heaviness and aching in your legs caused by swelling or varicose veins. It can optimize your muscle tone and function, relieve muscle strain and fatigue, and reduce strain on your joints. Pregnancy massage reduces stress and promotes relaxation, contributing to a healthier pregnancy. If you have been told that your pregnancy is high risk, please notify the therapist.

Please read and sign the acknowledgement below if you are receiving a pregnancy massage today.

I have received and read written information concerning the possible benefits of massage therapy during pregnancy. I verify that I am experiencing a low risk pregnancy. I stated all my known conditions. I understand that I will be receiving massage therapy for the purpose of stress reduction, relief from muscle tension or spasm or for increasing circulation and energy flow. I understand and agree that I am receiving massage therapy entirely at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part of the aforesaid massage therapist I HEREBY HOLD HARMLESS AND INDEMNIFY the therapist and her principals and agents from all claims and liability whatsoever.

Signature : _____ Date : _____
 Message Client

Signature : _____ Date : _____
 Message Therapist