CONFIDENTIAL HEALTH QUESTIONNAIRE – Massage Form

Name: _____ Date: _____

Have you had any recent injuries, illnesses, surgeries, or allergies?

_____

_____

What type of work do you do? Are there any physical problems that regularly occur?

_____

_____

Are you taking any prescription medications, herbs, supplements, or homeopathic remedies?

Yes_____ No_____ What kinds? _____

When was your last massage? _____

Are you allergic to oils or scents? Yes_____ No_____

Do you wear contact lenses? Yes _____ No_____

Health Conditions

Check any of the following you have or have had in the past 6 months.

___ Heart Condition
___ Inflammation
___ Blood Clots
___ Bruise easily
___ High Blood Pressure
___ Low Blood Pressure
___ Diabetes
___ Breathing Difficulties
___ Bursitis
___ Allergies _____
___ Headaches
___ Cancer
___ Edema Swelling
___ Pregnancy
___ Severe Menstrual cramping
___ Herniated Discs
___ Fractures
___ Endometriosis
___Communicable Disease
___ Herpes
___ Seizures
___ Arthritis
___ Fatigue
___ Sprains/strains
___ Numbness / Tingling
___ Chronic Pain
___ Rashes
___ Scars
___ Open Cuts or Sores
___ Skin Disease
___ Melanoma
____ Varicose veins

Anything else you would like to communicate about your health history:_____

_____

_____

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