Massage Therapy Questionnaire

Name: _____ Date of Initial Visit: _____

Address: _____

City, State, Zip: _____

Phone: (Day) _____ (Evening) _____ (Cell) _____ (Email) _____

Date of Birth: _____

Occupation: _____ Employer: _____

Referred By: _____ Physician: _____

1) Have you ever had Massage Therapy before? Yes____ No____

2) Do you have difficulty lying on your front, back, or side? Yes____ No____

3) Do you have allergic reactions to oils, lotions, ointments, liniments, or other substances put on your skin?

Yes____ No____ If yes, please explain _____

4) Do you wear contact lenses ( ), dentures ( ), a hearing aid ( )?

5) Do you experience stress in your work, family, or other aspects of your life? Yes____ No____

-How would you describe your stress level? Low___ Medium ___ High ____ Very High ____

-If high, how do you think your stress has affected your health? Muscle Tension ( ),

-Anxiety ( ), Insomnia ( ), Irritability ( ), Other _____

6) For women: Are you pregnant? Yes ___ No ___ If yes, how many months? _____

7) What is your major complaint, if any that you want to improve? _____

_____

8) When did you first notice this complaint? _____

9) What event(s) brought it on? _____

_____

10) What activities aggravate the condition? _____

11) What have you done to get relief? _____

12) What are your expectations for this visit?

_____

13) Are you currently under medical supervision? Yes ____ No ____

14) Are you currently taking any medications? Yes ___ No ___ If yes, please list: _____

_____