

# Massage Screening Questionnaire

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Home#(\_\_\_\_) \_\_\_\_\_ Work#(\_\_\_\_) \_\_\_\_\_ Cell#(\_\_\_\_) \_\_\_\_\_

Best time(s) to call \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_ WorkHours \_\_\_\_\_

Description of what you do at work \_\_\_\_\_

How did you hear about me? Who may I thank for referring you? \_\_\_\_\_

Purpose of Massage: Relaxation or addressing an injury \_\_\_\_\_

What type of care have you received for the health challenge you are currently experiencing. Please circle:  
Massage Therapy    Chiropractic    Acupuncturist    Contact Reflexologist    Medical Doctor    Other

What response did you have from the previous treatment? \_\_\_\_\_

Description of injury: \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What questions or concerns might you have? \_\_\_\_\_

Have you previously had a massage? Yes \_\_\_\_\_ No \_\_\_\_\_  
When? \_\_\_\_\_ Frequency \_\_\_\_\_ Modality used \_\_\_\_\_

***If you answer "yes" to any of the following questions, please explain as clearly as possible:***

- |  |   |
|--|---|
| <b>Y N</b> Do you frequently suffer from stress?                               | <b>Y N</b> Have you had any broken bones in the past two years?   |
| <b>Y N</b> Do you have diabetes?   | <b>Y N</b> Have you been in an accident or suffered any injuries in the past two years?                   |
| <b>Y N</b> Have you experienced frequent headaches?                            | <b>Y N</b> Do you have tension or soreness in a specific area? Please specify: _____                      |
| <b>Y N</b> Are you pregnant?   | <b>Y N</b> Do you have cardiac or circulatory problems?   |
| <b>Y N</b> Do you suffer from arthritis?                                       | <b>Y N</b> Do you suffer from back pain?  |
| <b>Y N</b> Are you wearing contact lenses?                                     | <b>Y N</b> Do you have numbness or stabbing pains anywhere?   |
| <b>Y N</b> Are you wearing dentures?   | <b>Y N</b> Are you sensitive to touch or pressure in any area?  |
| <b>Y N</b> Do you have high blood pressure?                                    | <b>Y N</b> Have you ever had surgery?   |
| <b>Y N</b> If "yes" to previous questions, are you Taking medication for this? | <b>Y N</b> Do you have any medical condition, or are you taking any medications that I should know about? |
| <b>Y N</b> Do you suffer from epilepsy or seizures?                            |   |
| <b>Y N</b> Do you suffer from joint swelling?                                  |   |
| <b>Y N</b> Do you have varicose veins?   |   |
| <b>Y N</b> Do you have any contagious diseases?                                |   |
| <b>Y N</b> Do you have osteoporosis?   |   |
| <b>Y N</b> Do you have any allergies?  |   |
| <b>Y N</b> Do you bruise easily?   |   |

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that the massage/bodywork I receive is provided for the basis purpose of relaxation and relief of muscular tension. If I experience any pain during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or body work should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or qualified medical specialist for any mental or physical ailment of which I am aware. I understand the massage/bodywork therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, 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 shall be no liability on the therapist's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapists Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Consent to Treatment of Minor:*** By my signature below, I hereby authorize \_\_\_\_\_ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian \_\_\_\_\_ Date: \_\_\_\_\_

***For Therapist Use Only***

Expectations/Goals: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_