HEALTH QUESTIONAIRE

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Name: _____ Date: _____ Phone (W & D) _____

Street Address _____

City, State & Zip _____

Birth Date _____

Current Occupation _____ Email _____

Certain conditions may be contraindication for massage.
Please answer the following questions carefully.

Illnesses/injuries/surgeries in the past two years?

_____

_____

Current/chronic/recent illness or condition? _____

_____

Any numbness? _____

Are there any areas of your body which are weakened or sensitive from injury or illness, past or present?

_____

Do you have allergies to essential oils? _____

Skin rashes or irritations? _____

Do you have: High blood pressure, clots or irregular pulse? (please circle)

Do you take any medications? Please list them. _____

Do you get headaches? If yes, how often and when? _____

Are you pregnant? Yes / No Do you wear contact lenses? Yes / No (circle one)

Are you currently under any medical, psychological, chiropractic or naturopathic treatment program? If so, for what?

_____

Is this your first professional bodywork session? _____

What are your massage goals for today? Please specify if you'd like relaxation or therapeutic deep tissue.

_____

I understand that some conditions may be contraindications for massage and have provided information on this form to the best of my knowledge.

_____ _____

Signature Date