Vitality Natural Health and Wellness Center, LLC

"Promoting health and wellness through enhancement of the mind, body and spirit."

MASSAGE HEALTH HISTORY QUESTIONNAIRE

SUCCESSFUL MASSAGE SESSIONS ARE ONLY POSSIBLE WHEN THE PROVIDER HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

PATIENT: ____ DATE: ___________________________

Is this your first professional massage? ☐ Yes ☐ No If no, how frequently do you get a massage? ___________________________

I. Summary of Current/Past Conditions

	Date Began:
	Date Began:
	Date Began:

Do you have any chronic, ongoing pain that you deal with on a regular basis? ☐ Yes ☐ No

Please explain: ____

Describe what activities cause this pain and/or make it worse: ____

Describe what activities make the pain better: ____

This condition(s) interferes with: ☐ Work ☐ Sleep ☐ Exercise ☐ Other _________________

This condition is: ☐ Getting worse ☐ Getting better ☐ Staying the same

What do you believe is the cause?

How is the condition being treated?

Are you currently experiencing any of the following conditions? ☐ Contagious disease; please explain: ___________________________

☐ Cold or Flu ☐ Inflammation ☐ Fever ☐ Infection ☐ Diarrhea ☐ Constipation ☐ Vomiting

II. Goals and Expectations (Please tell us your goals and expectations for the massage session.)

III. Hospitalizations, Surgeries, Accidents/Injuries

(What hospitalizations, surgeries or accidents/ injuries have you had?)

________________________________ Year: _______	________________________________ Year: _______
________________________________ Year: _______	________________________________ Year: _______

What kind of care did you receive for your accidents or injuries? ____

Do you feel that you have recovered from these events? ☐ Yes ☐ No Please explain: ___________________________

IX. Medical History

(Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.)

Musculo-Skeletal:
- ☐ Headaches
- ☐ Joint stiffness/swelling
- ☐ Spasms/cramps
- ☐ Broken/fractured bones
- ☐ Strains/sprains
- ☐ Back, hip pain
- ☐ Shoulder, neck, arm, hand pain
- ☐ Leg, foot pain
- ☐ Chest, ribs, abdominal pain
- ☐ Problems walking
- ☐ Jaw pain/TMJ
- ☐ Tendinitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Bone or joint disease
- ☐ Other: ____________________

Circulatory and Respiratory
- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold feet or hands
- ☐ Cold sweats
- ☐ Swollen ankles
- ☐ Pressure sores
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Stroke
- ☐ Heart condition
- ☐ Allergies
- ☐ Sinus problems
- ☐ Asthma
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphedema
- ☐ Other: ____________________

Skin:
- ☐ Rashes
- ☐ Allergies
- ☐ Athlete's Foot
- ☐ Warts
- ☐ Moles
- ☐ Acne
- ☐ Cosmetic surgery
- ☐ Other: ____________________

Digestive:
- ☐ Nervous stomach
- ☐ Indigestion
- ☐ Constipation
- ☐ Intestinal gas/bloating
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Irritable bowel syndrome
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Adaptive aids
- ☐ Other: ____________________

Nervous System:
- ☐ Numbness/tingling
- ☐ Twitching of face
- ☐ Fatigue
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Ulcers
- ☐ Paralysis
- ☐ Herpes/shingles
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Chronic Fatigue Syndrome
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's disease
- ☐ Spinal cord injury
- ☐ Other: ____________________

Reproductive System:
- ☐ Pregnancy:
  - ☐ Current # of weeks: ________
  - ☐ Previous
- ☐ PMS
- ☐ Menopause
- ☐ Pelvic Inflammatory Disease
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Fertility concerns
- ☐ Prostate problems

Other:
- ☐ Loss of appetite
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Drug use ____________________
- ☐ Alcohol use _________________
- ☐ Nicotine use _________________
- ☐ Caffeine use _________________
- ☐ Hearing impaired
- ☐ Visually impaired
- ☐ Burning upon urination
- ☐ Bladder infection
- ☐ Eating disorder
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Post/Polio Syndrome
- ☐ Cancer
- ☐ Infectious disease (please list) ______________________________
- ☐ Other congenital or acquired disabilities (please list) __________ ______________________________
- ☐ Surgeries _____________________
- ☐ Other: ________________________

For clients who need mobility assistance, please give your
Height: ________ Weight: ________

IX. Medications, Supplements, Vitamins, Herbs

Medication:	Dosage:	Condition Treated:	Medication:	Dosage:	Condition Treated:

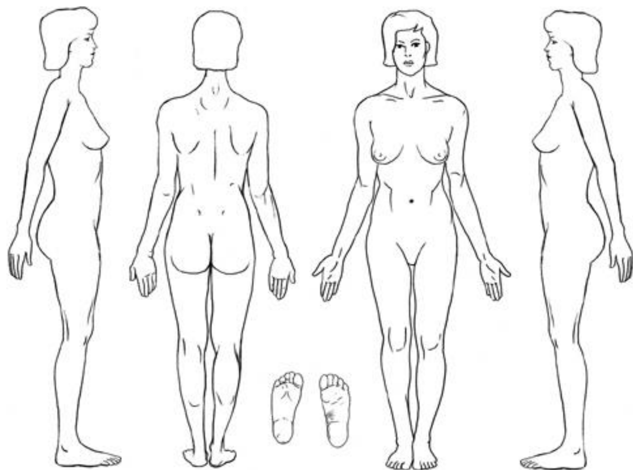
X. Allergies (Are you hypersensitive or allergic to any of the following?)

Medications: ______________________________	Reaction: ____________________
Foods: ______________________________	Reaction: ____________________
Environmentals: ______________________________	Reaction: ____________________
Creams/Lotions/Perfumes: ______________________________	Reaction: ____________________

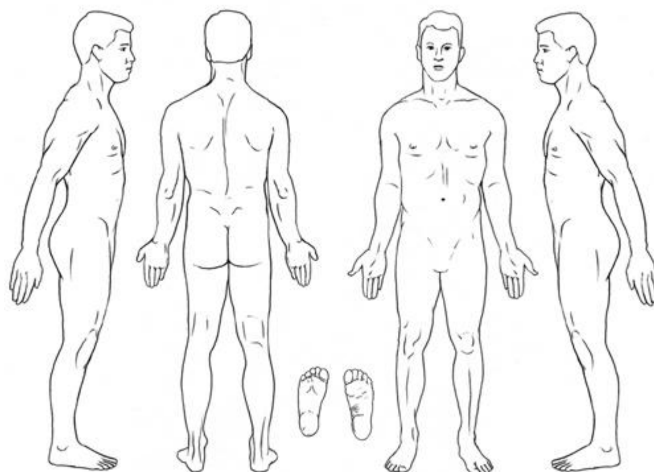
XI. Target Areas

(On the diagram, please mark as follows: Put an X on any painful area. Rate pain on a scale of 1-10. Shade in any stiff or sore areas. Circle areas of other concern and describe the condition.)

FEMALE BODY DIAGRAM



MALE BODY DIAGRAM



XII. Please Read and Sign

I understand that the massage/bodywork I receive is intended to enhance relaxation, reduce pain caused by muscle tension and stress, increase range of motion, improve circulation and offer a positive experience of touch. The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me.

I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my primary caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. I am aware that massage/bodywork may be contraindicated with certain medical conditions and/or symptoms and that a referral from my primary care provider may be required prior to service being provided. I have stated all medical conditions and medications that I am aware of and will update the massage practitioner of any changes in my health status. I understand that there should be no liability on the practitioner'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 full payment of the session.

I have received a copy of Vitality Natural Health and Wellness Center's policies. I understand them and agree to abide by them.

Signature: ____ Date: ____________________