A Time For You.

Confidential Health Questionnaire

Client Name: _____ Today's Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

D.O.B.: _____ Home Phone: _____

Occupation: _____ Work Phone: _____

Age: _____ Height: _____ Have you ever received Massage Therapy before? _____ If so, when? _____

What brings you here today? _____

_____

Is there any area where you would like extra time spent, any area where you have muscle pain/stiffness/tension? _____

Daily Activities/Sports/Hobbies/Exercise: _____ Daily caffeine intake: _____

Posture assumed most of the day: _____ Average hours of sleep per night: _____

Daily Water intake: _____ Known allergies (lotion, oil, nuts): _____

Do you consume any of the following:

Tobacco _____ Vitamins (please specify) _____

Alcohol _____ Herbal Supplements (please specify): _____

Illegal Substances _____ Over the counter meds

(Tylenol, Advil, allergy etc. Please specify): _____

Medical History *(Please indicate below any significant medical problems that could influence the type or depth of work done in any given area.)*

Skin condition *(acne, rash, allergies, skin cancer, abscess, open sores)* Other: _____

Lymphatic condition *(swollen glands, lymphoma, lymph edema)* Other: _____

Recent injury or accident *(Whiplash, sprain, deep bruise)* Other: _____

Circulatory condition
(Heart disease, varicose veins, phlebitis, arrhythmia, arteriosclerosis) Other: _____

Neurological condition
(sciatica, numbness/tingling of any area if skin, stroke, or epilepsy) Other: _____

Joint problems *(osteoarthritis, rheumatoid arthritis, gout,*
hyper mobile joints, sacroiliac problems, disc) Other: _____

Bone conditions *(osteoporosis, previous fracture, cancer)* Other: _____

Headaches *(migraines, PMS, tension, cluster)* Other: _____

Emotional difficulties *(depression, anxiety, psychotic episodes)* Other: _____

Stress related disorders *(stomach ulcers, PTSD)* Other: _____

Previous surgery *(Please state type and date):* _____

Other medical considerations:

Do you use any of the following: (contacts, dentures, hearing aids, pins, pacemaker, artificial joints) _____

Blood condition *(hemophilia, HIV, Hepatitis A,B,C,D,E)* Other: _____

Diabetes _____ Asthma _____ Dizziness _____

Are you Pregnant _____ Blood Pressure (high, low) _____

Are you under medical care or supervision? _____ For what condition? _____

Are you currently taking any prescription medication: (Name & dosage): _____

Have you ever received Chiropractic care: _____

For what condition:

Do I have consent to contact your Health care provider or Chiropractor for consultation if needed? _____

Health care provider, i.e. DR, PA, APRN: _____

Phone number: _____

Name of Chiropractor: _____

Phone Number: _____

Signature: _____ Date: _____