**Doctors for Kids – Wellness Division**

**Massage Health Questionnaire**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name | | Cell phone | | | | Work phone | |
| Email | | | | Home phone | | | |
| Street | | City | | | | State/Zip | |
| Date of Birth | □ Male  □ Female | | Age | | Height | | Weight |
| Occupation | | Employer | | | | Physician | |
| Emergency Contact - Name (First & Last) | | Emergency Contact - Phone | | | | Relation to you | |

Is this your first professional massage? Y N

What have you liked or disliked with previous massage?

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

Is there a specific part of the body you would like to focus on?

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Is there a specific posture or position you assume most of the day?

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**CURRENT HEALTH:**

Are you presently experiencing any cold or flu like symptoms? Y N

Please inform the therapist, the session might need to be rescheduled

Please list any current medications, vitamins, supplements or herbs you are taking

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

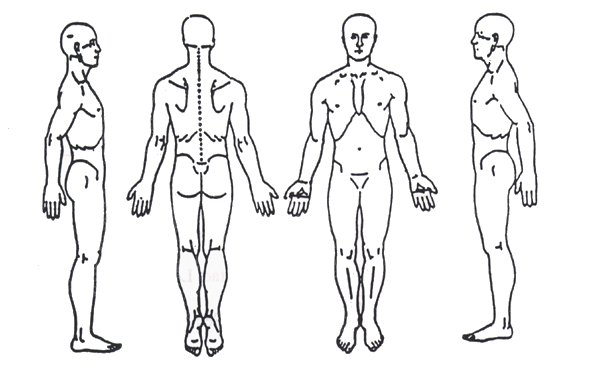
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a regular exercise routine? Y N

What type of exercise do you participate in?

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

Please indicate any areas of pain, tension, tingling or numbness on the diagram below:



|  |  |  |
| --- | --- | --- |
| **MEDICAL HISTORY**: **Circulatory**  o Heart disease  o High / Low Blood Pressure  o Varicose veins  o Peripheral Artery Disease  o Blood clots  o Hemophilia  o Palpitations  o Stroke  o Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Digestive**  o Crohn’s Disease  o IBS / Colitis  o Constipation / Diarrhea  o Gallstones  o Ulcers  o Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Other Medical Issues**  o Diabetes Type I / Type II  o Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  o Thyroid Hyper / Hypo  o HIV/AIDS  o Hepatitis  o Lupus  o Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Respiratory**  o Asthma  o Pneumonia  o COPD  o Emphysema  o Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Neurological Conditions**  o Seizures (type) \_\_\_\_\_\_\_\_\_\_\_  o Multiple Sclerosis  o Carpal Tunnel  o Bell’s Palsy  o Tingling/Numbness  o Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Emotional Difficulties**  o Depression  o Anxiety  o Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Allergies (please specify)**  o Nuts  o Environmental  o Medications  o Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Skin Conditions**  o Acne  o Eczema / Psoriasis  o Fungal Infections  o Athlete’s Foot  o Open cuts / sores  o Bruises  o Sunburn  o Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Musculoskeletal**  o Osteoporosis  o Arthritis  o Rheumatoid Arthritis  o Gout / Bursitis  o Fractures / Strains / Sprains  o TMJ  o Tendonitis  o Fibromyalgia  o Whiplash  o Cysts / Lypomas  o Headaches  o Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Skin Test for "Special Oil" Please insert Name of Oil: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Was Performed 24 hours or more ago and there has been no reaction (please initial) \_\_\_\_\_\_\_\_\_**

**To the best of my knowledge the information completed on all three pages of this document is correct**

**Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Informed Consent for Massage**

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that massage/bodywork practitioners 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner’s part should I fail to do so. Children under the age of 18 must be accompanied by parent or legal guardian at all times during massage.

Signature required prior to each massage and any changes documented and initialed prior to each massage.

**Parent/Guardian Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Therapist Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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