



## Massage Therapy Medical Questionnaire

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary reason for appointment: \_\_\_\_\_

**Medical History** *Please check off all that apply*

- |  |   |
|--|---|
| <input type="checkbox"/> Hypertension (High Blood Pressure)  | <input type="checkbox"/> Respiratory problems           |
| <input type="checkbox"/> Headaches                           | <input type="checkbox"/> Circulatory conditions         |
| <input type="checkbox"/> Allergies                           | <input type="checkbox"/> Osteoporosis                   |
| <input type="checkbox"/> Heart condition                     | <input type="checkbox"/> Skin conditions or irritations |
| <input type="checkbox"/> Nervous Disorders                   | <input type="checkbox"/> Cancer                         |
| <input type="checkbox"/> Arthritis                           | <input type="checkbox"/> Cholesterol                    |
| <input type="checkbox"/> TMJ (Jaw problems)                  | <input type="checkbox"/> Poor circulation               |
| <input type="checkbox"/> Whiplash                            | <input type="checkbox"/> Hepatitis or HIV               |
| <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Fainting or dizziness          |
| <input type="checkbox"/> Stomach or digestive tract problems |   |

**Do you have any past history of the following?**

- |   |  |
|---|--|
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Arm/Leg pain                |
| <input type="checkbox"/> Upper back/Neck pain | <input type="checkbox"/> Pain of the abdomen/chest   |
| <input type="checkbox"/> Lower back pain      | <input type="checkbox"/> Irritation of the eyes/ears |
| <input type="checkbox"/> Fractures            | <input type="checkbox"/> Surgery                     |

**Current Conditions**

Please describe your present symptoms as best as you can:  
(ie: Where, How When, What do your symptoms feel like...etc)

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**Have you had any of the following regarding your present condition?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Physician's Examination | <input type="checkbox"/> X-ray           | <input type="checkbox"/> Physiotherapy |
| <input type="checkbox"/> Chiropractic Treatment  | <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Other         |

Are you currently taking any medication? (Prescription, Herbal, Non-Prescription etc,) *Please list.*

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**Does your immediate family have any of the following conditons?**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Liver Disorders | <input type="checkbox"/> Back Pain                                |
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Cancer                                   |
| <input type="checkbox"/> Respiratory Disorders | <input type="checkbox"/> Hypertension    | <input type="checkbox"/> Neurological conditions (MS, Stroke etc) |

The information contained on this form is true and to the best of my knowledge.

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