

IN TOUCH

Massage Therapy

Confidential Health History Questionnaire

Welcome to our clinic. Please help us provide you with a complete evaluation by taking a few moments to complete this questionnaire. If you have any questions, please ask. If there is anything you wish to bring to our attention that is not indicated on this form, please be sure to note it at the bottom, or let us know. THANK YOU!

Name: _____ Email: _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone: (C) _____ (H) _____ (W) _____

How did you learn about **IN TOUCH?** (Please Circle)

Sign _____ Yellow Pages _____ Medical Referral _____ Friend/Relative _____ Other _____

What is your Occupation? _____ **Do you have any allergies?** _____

Are you currently taking any medication(s)? (Please Circle)

Yes _____ No _____ If yes, please specify: _____

What is your chief complaint? (Please Circle)

Stress _____ Pain _____ Medical Condition _____ Limited Range of Motion _____

When did you first notice these symptoms? _____

Have you been given a diagnosis by a Physician? Yes _____ No _____

If yes, please explain: _____

What kinds of treatment or therapy have you tried? (Please Circle)

Therapeutic Massage _____ Physical Therapy _____ Chiropractic _____ Acupuncture _____

Surgery _____ Other _____

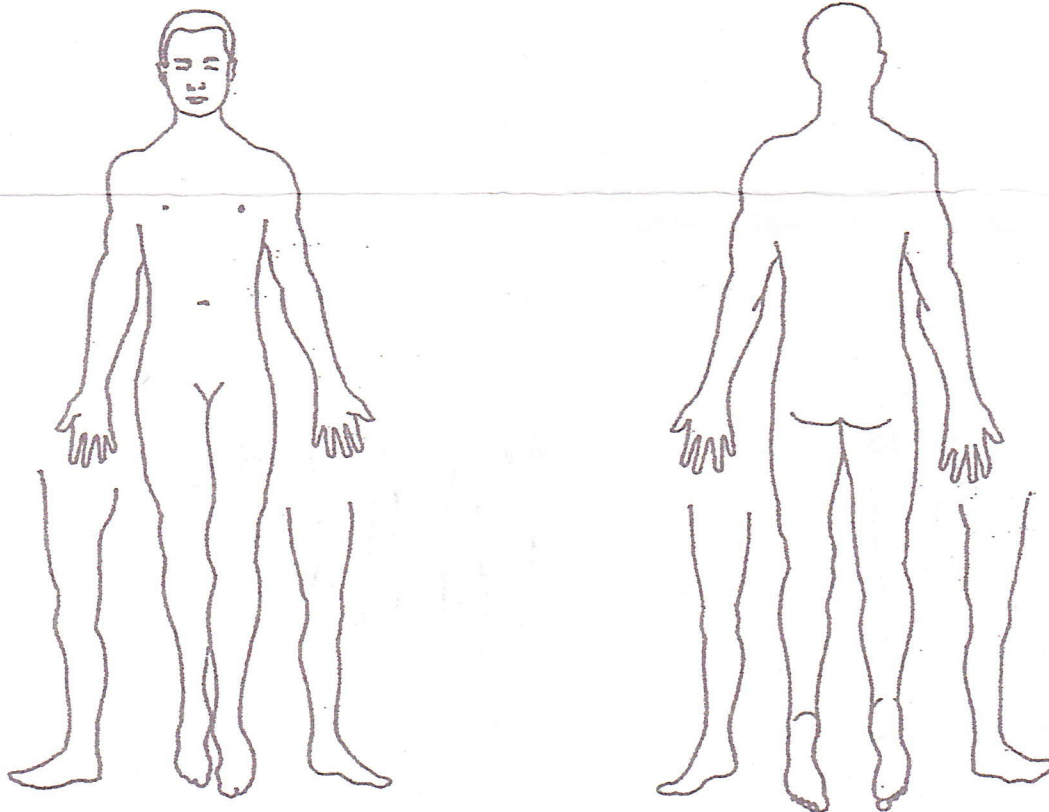
(PLEASE ALSO COMPLETE THE BACK OF THIS FORM)

Confidential Health History Questionnaire (Continued)

Do you have a history of any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Accident | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Whiplash | <input type="checkbox"/> Dislocations | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Surgery | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Nervous Tension | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Contact Lenses |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Colitis | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Arthritis/Bursitis | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Gout | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> HIV Hepatitis |

Please shade areas of discomfort:



I understand that this massage is not a replacement for medical care and that no diagnosis will be given. I am responsible for paying the cancellation fee for any appointment cancelled less than 24 hours prior to the scheduled massage.

Signature

Date