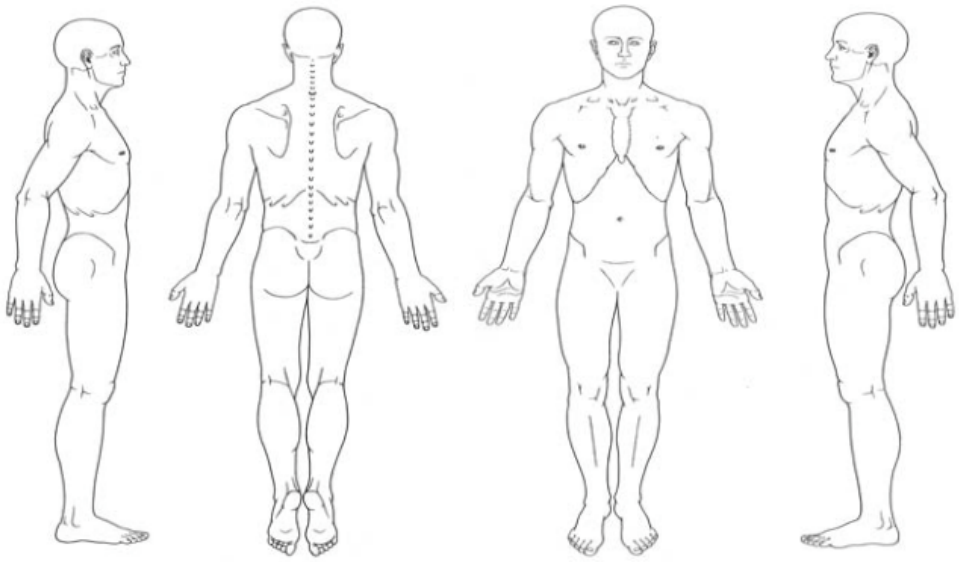
Health Questionnaire

Contact details	Date:
Name	
Date of birth	
Occupation	
Contact phone	
E-mail address	
How did you hear about us?	

Symptoms	
What are your current symptoms?	
What aggravates your condition?	
What improves your condition?	
Constant/comes and goes?	
Previous treatment?	
Do these conditions affect your work/sleep/ daily routine?	

Indicate where you have pain or other symptoms



Please indicate if you have/are any of the following:

Arthritis	Sensitive skin	Disc problems	Abdominal pain
High/low blood pressure	Carpal tunnel/OOS	Cramps	Heart problems/ angina
Osteoporosis	Numbness/pins and needles	Hip/knee replacement	Irritable bowel
Pregnant	Headaches	Sciatica	
Seizures/ convulsions	Tension/Dizziness	Shin splints	

Please elaborate if you relate to any of the above or have any other conditions your therapist should know about.

Are you taking any medication? If so, what?

Please list as best you can any relevant:

Exercise	
Past operations (how recent)	
Injuries (how recent)	

I hereby give consent for Massage Therapy Treatment. I have the right to refuse treatment at any time. I do not hold my therapist responsible for any ill-effects massage may cause and agree to consult a doctor if I have any adverse reaction to massage whatsoever.

Signed_____ Date_____