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Confidential Health Questionnaire for Massage Therapy

Your Name: _____ Birth Date: _____
Occupation: _____ Phone (H): _____
Address: _____ Phone (W): _____
Email: _____

Reason for visit: relaxation / wellness / injury
Is this your first massage? Y N
Do you wear contact lenses? Y N

Physician: _____
Referred by PT / MD / DC/ Other _____
How did you find OMA? _____

Please check all of the conditions you presently experience or have experienced in the past.

☐ Neck/Spinal injury	☐ Back Pain	☐ Tendinitis	☐ Allergies, esp. oils/nuts
☐ Cancer Treatment	☐ Sprains / Strains	☐ Headaches	
☐ Hepatitis	☐ Muscle Spasm	☐ Stress	☐ Diabetes
☐ Fever or Cold	☐ Muscle Tension	☐ Difficulty Sleeping	☐ Asthma
☐ Any Bleeding Disorder	☐ Chronic Pain	☐ Digestive Problems	☐ Varicose Veins
☐ Phlebitis	☐ Sciatica	☐ Rash/Skin Disorder	☐ TMJ Syndrome
☐ HIV +	☐ Arthritis	☐ Fibromyalgia	☐ Stiff Joints
☐ Other Infectious Disease	☐ Degenerative Disc		☐ Pregnant or Menstruating
	☐ Emotional Change		

If necessary, use the back of the page to answer the following questions.

Please list any other conditions not listed above for which you are under a doctor's care.

Please provide details for the boxes you checked above. _____

Please list all medications and herbs that you are taking. _____

Please list past injuries, surgeries and accidents. _____

A message for you: Massage therapy provides many important health benefits, is a relaxing experience, and **is completely non-sexual**. Since oil and/or lotion may be used on your skin during massage, it is recommended that you remove all of your clothing. You will at all times be covered with a sheet that is pulled back to expose only the area being treated.

Please read before signing: The information that I provided above is true, accurate, and complete to the best of my knowledge. I understand that a massage therapist does not diagnose illness, disease, or any other physical or mental disorder, nor does s/he prescribe medications or perform spinal manipulations. I understand that massage therapy is not a substitute for a medical examination or diagnosis, and it is recommended that I see a physician for any physical ailment that I may have.

My signature below indicates that I have read and understood the statements above, and I authorize release of this information to applicable third parties.

_____ _____
Client's Signature Date