

Rise Up Therapeutic Massage

Confidential Questionnaire for Massage

Date _____

Name (First, Last, M.I.) _____

Address (with city & zip) _____

Email: _____ Phone: _____

Date of Birth: _____ Sex F M How did you learn about us? _____

Emergency contact name and phone: _____

HEALTH HISTORY

Have you ever experienced any of the following? (mark **C** for current, **P** for past)

_____ HIV/AIDS	_____ Constipation	_____ Herpes	_____ Sciatica
_____ Allergies	_____ Diarrhea	_____ High Blood Pressure	_____ Stiff Joints
_____ Anemia	_____ Diabetes	_____ Low Blood Pressure	_____ Skin Allergies
_____ Athletes Foot	_____ Digestive Problems	_____ Insomnia	_____ Sprains/ Strains
_____ Arthritis	_____ Disc Problems	_____ Excess Stress	_____ Stroke
_____ Back Pain	_____ Diverticulitis	_____ Migraines	_____ Swollen Feet/ Legs
_____ Bone Fractures	_____ Eczema	_____ Muscle Spasms	_____ Tendonitis
_____ Bursitis	_____ Epilepsy/ Seizures	_____ Numbness	_____ Tingling
_____ Cancer	_____ Fibromyalgia	_____ Phlebitis	_____ Tumors
_____ Chronic Fatigue	_____ Headaches	_____ Psoriasis	_____ Varicose Veins
_____ Circulatory Problems	_____ Heart Attack/ Ailments	_____ Rashes	_____ Whiplash
_____ Colitis	_____ Hemophilia	_____ Ringworm	_____ Pregnant/ trying

Other: _____

Any accidents, injuries or surgeries, current or in the past? _____

Please explain any medical care that you are currently receiving or medications _____

Please describe your main goals & areas of focus for massage today. _____

Please Read & Sign the Following

I acknowledge that the above information is complete and accurate to the best of my knowledge and will notify my LMP of any changes in my physical condition prior to treatment or any changes in the information on this form.

Missed appointment or cancellation with less than 24 hours notice will be charged the full amount of scheduled service.

Client Signature _____

Date _____