RETURNING BALANCE THERAPIES

Glenwood Springs
970-618-2492

Massage Health Questionnaire

Name_____Date_____
Address_____City_____State_____Zip_____
Telephone (Circle preferred) Home_____ Work_____ Cell_____
Email_____ Referred By_____
Height_____ Weight_____ Birth Date_____ Marital Status _____Male __Female__
Occupation_____Employer_____
Emergency contact Name and Phone Number _____
Are you pregnant?_____ Childbirth history_____
Date of last massage?_____

Insurance Information:
Insurance Company Name_____Policy Number_____
Are you currently under a medical doctor's care:_____ Explain_____
_____
Physician Name_____Phone_____
Please list prescription medications_____
_____

Medical Information:
List accidents/Injuries, Hospitalizations and Surgeries: When they occurred and treatment received:
_____
_____
_____
_____

Are there any lingering effects from the above or do you feel you have recovered? _____
_____
_____
_____

Do you have chronic or ongoing pain?_____Please describe along with any treatment you've received.
_____
_____

Do activities affect the pain?_____ Please describe. _____
_____

Please list over the counter medications, supplements and/or herbs you're taking and reasons_____
_____

Please put an "**X**" beside anything that is currently a health challenge. Put a "**P**" beside a past problem.

Musculoskeletal:
__Osteoporosis
__Arthritis
__Hypothyroidism
__Fibromyalgia
__Gout in _____
__Bursitis
__Plantar Fascitis
__Cysts/Lipomas
__TMJ
__Chronic Headaches
__Tendonitis
__Whiplash
__Strains/Sprains
__Chronic pain in:
__Neck
__Low-back
__Mid-back
__Upper-back
__Hip
__Arm
__Leg
__Shoulder
__Wrist/Hand
__On computer more than 2 hours a day. # of hours_____

Respiratory
__Pneumonia
__Asthma
__Breathing problems
__Sinusitis
__Other_____
_____

Digestive:
__Ulcers
__Colitis
__IBS
__Crone's Disease
__Constipation
__Diarrhea
__Gallstones
__Gas/Bloating
__Chronic Indigestion

Circulatory
__Heart Problems_____
_____
__Stroke
__Palpitations
__Mitral valve prolapse
__Anemia
__Hemophilia
__Hypertension
__Low blood pressure
__Peripheral Artery Disease
__Raynaud's Disease
__Varicose veins
__Blood clots/Phlebitis

Skin
__Fungal infections
__Athlete's Foot
__Impetigo
__Eczema/Dermatitis
__Psoriasis
__Easily irritated skin
__Other_____

Nervous System:
__Dizziness
__ALS
__Multiple Sclerosis
__Parkinson's Disease
__Bell's Palsy
__Neuritis
__Spinal cord injury
__Trigeminal Neuralgia
__Seizures/Epilepsy

Other
__Diabetes
__Pregnancy
__Cancer
__Kidney disease
__Hepatitis
__HIV/AIDS
__Lupus
__Postoperative:_____
__Cystitis
__High Stress
__Grieving
__Anxiety/Panic attacks
__Bipolar
__PMS/Menopause difficulties
__Poor sleep/Insomnia
__Allergies affecting:
__Facial skin
__Body skin
__Nose/Sinuses
__Eyes
__Stomach/Gut
__Orthopedic pins or plates

Is there anything else your massage therapist should know about you?_____
_____

Exercise routines
Time/Day per week_____ Type of activity_____
_____

What do you hope to achieve from this appointment?_____
_____

I certify the above information is accurate. I understand that Massage Therapists do not diagnose disease or prescribe drugs and that they are not a substitute for medical care. I agree to alert my practitioner of any physical/emotional changes that occur. **24-Hour cancellation policy: I understand that a missed appointment without 24-hour notification, might incur charges that I must pay.**

Signature_____Date_____