

## DESERT SOUL MASSAGE THERAPY HEALTH QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ e-mail: \_\_\_\_\_

Home Phone (eve): \_\_\_\_\_ Work Phone (day) \_\_\_\_\_

Occupation: \_\_\_\_\_ DOB: \_\_\_\_\_

Referred by: \_\_\_\_\_

Primary reason for your visit: \_\_\_\_\_

Do you currently have any of the following conditions? (**Check all that apply**)

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Emotional changes      | <input type="checkbox"/> Skin disorder        | <input type="checkbox"/> Chronic pain      |
| <input type="checkbox"/> Blood clots          | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Infectious diseases  | <input type="checkbox"/> Acute pain        |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Inflammation           | <input type="checkbox"/> Fever                | <input type="checkbox"/> TMJ pain          |
| <input type="checkbox"/> Heart condition      | <input type="checkbox"/> Arthritis/joint issues | <input type="checkbox"/> Cold/Virus/Flu       | <input type="checkbox"/> Neck/spine injury |
| <input type="checkbox"/> Varicose veins       | <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Sciatica          |
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Cancer or tumors       | <input type="checkbox"/> Broken bones         | <input type="checkbox"/> Tendonitis        |
| <input type="checkbox"/> Liver disease        | <input type="checkbox"/> Kidney disease         | <input type="checkbox"/> Stroke damage        | <input type="checkbox"/> Epilepsy          |
| <input type="checkbox"/> Lymphatic conditions | <input type="checkbox"/> Multiple sclerosis     | <input type="checkbox"/> Digestive conditions | <input type="checkbox"/> Immune conditions |

List any other conditions not mentioned above: \_\_\_\_\_

Please state any recent or past injuries/skin conditions/surgery or other medical treatments: \_\_\_\_\_

Do you currently take any medications? **If yes, please list, including purpose:** (such as Heart, Blood thinners, Blood Pressure, Muscle Relaxant, Cortisone/Steroid, Anti-Inflammatory Medicines, etc.)

\_\_\_\_\_

Are you currently under the care of a health professional?  Yes  No

Health care provider's name: \_\_\_\_\_

Permission to consult with health care provider?  Yes  No

Are there any areas of your body that should be avoided or any areas where pressure should be avoided during the massage or Other Restrictions? Please describe: \_\_\_\_\_

Have you received a professional massage before?  Yes  No

If yes, how long ago was it and how was the experience for you? \_\_\_\_\_

\_\_\_\_\_

What results do you want from your massage session? \_\_\_\_\_

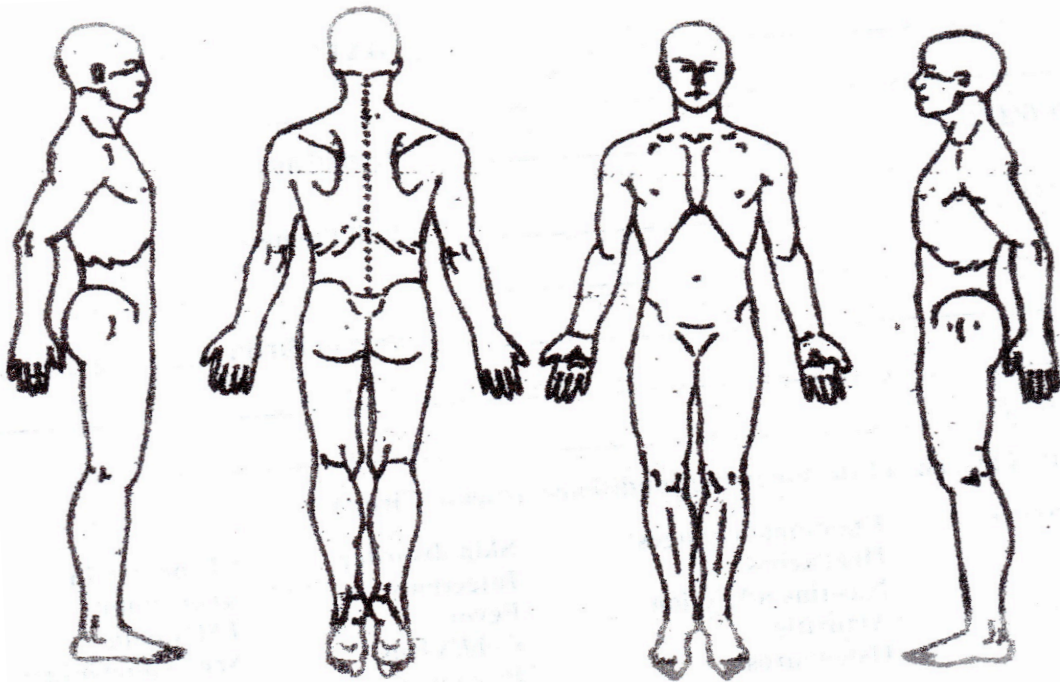
Are you currently experiencing pain? Where? Is the pain sharp or dull, constant or intermittent?

Please describe it, \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

Indicate tension-holding areas or areas of discomfort; rate on a scale of 1 to 10 the degree of pain, (10 being the worst.)



The type of massage you prefer:  Deep Muscular,  Soothing & Relaxing,  Combination,  Lymphatic Drainage,  Don't know,  Other \_\_\_\_\_.

**Because a massage therapist must be aware of any existing physical conditions that I have, I have listed all my known medical conditions and physical limitations, and I will inform you of any changes in my physical health. I understand that the massage therapy that I am given is for the purpose of stress reduction, relief from muscular tension or spasm and/or for improved circulation. I understand that a massage therapist can neither perform spinal manipulations nor diagnose disease or any other physical or mental disorder.**

**I understand that all information will be kept confidential unless I authorize its release.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Payment is due when services are rendered unless previous arrangements have been made.**

**THANK YOU**

**Patricia Torres-Espinoza BS, MBA, LMT 6702  
DESERT SOUL MASSAGE THERAPY**

**Date: \_\_\_\_\_**