



CONFIDENTIAL HEALTH QUESTIONNAIRE

REMEDIAL MASSAGE TREATMENT

Name _____ D.O.B. _____
(Please Print) Surname Given Names (in full)
Postal Address _____ Postcode _____
Email Address _____ Occupation _____
Telephone Home _____ Mobile _____ Work _____
Name of Emergency Contact _____ Telephone Number _____
Referred by _____

HEALTH INFORMATION

In your own words, please describe your reason for visit/history of complaint. _____

Are you sensitive to any essential oils? _____ Please list any allergies? _____

Areas to avoid during massage _____

Are there any accidents that the therapist should be aware of? _____

Do you have any other health complaints? _____

Name and address of your Medical Doctor _____

Please list any medications you are taking _____

Physical History

Please tick if you have had any of the following -

- | | | |
|----------------------------|--------------------------|--------------------------|
| Chronic Pain | Asthma or Lung Condition | Insomnia |
| Headaches/Migraines | Psoriasis | Epilepsy/Seizures |
| Cold/Flu/Fever | Phlebitis | Infectious disease |
| Diabetes | Varicose Veins | Sleep Disorder |
| Heart/Circulatory problems | Joint Replacement | General Fatigue |
| High Blood Pressure | Blood Clots | Hearing Problems |
| Chronic Fatigue | Arthritis | Vision Problems |
| Fibromyalgia | Stroke | Depression |
| Kidney Ailments | PMS Syndrome | HIV/Aids |
| Cancer/Tumors | TMJ Syndrome | Other Medical Conditions |
| Anxiety | Neck of Spine Injury | not listed - |
| Osteoporosis | Loss of Balance | _____ |
| Pregnancy | Numbness | _____ |
| Herpes | Skin Disorders/Rashes | _____ |
| Hernias | Nervousness | _____ |
| Shingles | Dizziness | _____ |
| Eczema | Allergies | |

I fully acknowledge that massage/bodywork professionals do not diagnose illness or disease, perform any type of spinal manipulation or prescribe medication and that nothing said throughout this session should be constructed as such. Because massage/bodywork should not be performed under certain circumstances – as there are small risks to some treatments, I agree to update the practitioner of any changes to my health as soon as I become aware of them, and release the massage professional from any liability if I fail to do so.

Client Signature _____ Therapist Signature _____ Date _____