



The Center for Integrative Healthcare & Healing
Massage Therapy Questionnaire

Name: _____ Date of Initial Visit: _____

Address: _____

City, State, Zip: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Date of Birth: _____ Occupation: _____

Referred By: _____ Current Physician: _____

1) Have you ever had Massage Therapy before? Yes _____ No _____

2) Do you have difficulty lying on you front, back or side? Yes _____ No _____

3) Do you have allergic reactions to oils, lotions, ointments, liniments, or other substances put on your skin?
Yes _____ No _____

4) Do you wear contact lenses (), dentures (), a hearing aid ()?

5) Do you experience stress in your work, family, or other aspects of your life? Yes _____ No _____

6) For women: Are you pregnant? Yes _____ No _____ If yes, how many months? _____

7) What is your major complaint, if any that you want to improve? _____

8) When did you first notice this complaint? _____

9) What event(s) brought it on? _____

10) What activities aggravate the condition? _____

11) What have you done to get relief? _____

12) What are you expectations for this visit? _____

13) Are you currently under medical supervision? Yes _____ No _____

14) Are you currently taking any medications? Yes _____ No _____ If yes, please list: _____

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Check the following conditions that apply to you, past and present.
Please add your comments to clarify the condition.

Musculo-skeletal

- Headaches
- Joint stiffness/swelling
- Spasms/Cramps
- Broken/fractured bones
- Strains and sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or Joint Disease
- Fibromyalgia
- Jaw Issues/TMJ
- Other _____

Skin

- Rashes
- Allergies
- Athlete's Foot
- Warts
- Moles
- Acne
- Cosmetic Surgery

Reproductive System - Women

- Pregnancy:
- Menopause
- PMS
- Endometriosis
- Pelvic inflammatory disease

Digestive

- Nervous stomach
- Indigestion
- Constipation
- Diarrhea
- Diverticulitis
- Irritable Bowl Syndrome
- Crohn's Disease
- Other _____

Other

- Cancer ___ Current ___ Remission
- Diabetes
- Depression
- Drug Use _____
- Alcohol Use _____
- Nicotine Use _____
- Caffeine Use _____
- Hearing Impairment
- Visual Impairment
- Infectious Disease _____

Circulatory and Respiratory

- Dizziness/lightheadedness
- Shortness of breath
- Asthma
- Sinus problems
- Fainting
- Pressure sores
- Varicose Veins
- Blood Clots
- Stroke
- Heart Condition
- Diabetes
- Swollen ankles
- Lymphedema
- High or Low Blood Pressure
- Numbness/tingling
- Other _____

Nervous System

- Herpes/Shingles
- Epilepsy
- Paralysis
- Fatigue
- Chronic pain
- Sleep Disorders
- Parkinson's Disease
- Spinal cord injury
- Muscular Dystrophy
- Cerebral Palsy
- Multiple Sclerosis
- Chronic Fatigue Syndrome
- Other: _____

Surgical History

- _____
- _____
- _____
- _____

Please list any additional comment regarding your health and well being: _____

All of the above information is correct to the best of my knowledge. I realize that this session is not intended to diagnose or treat any condition that I may have, and is purely for the therapeutic purposes. I will not hold the Massage Therapist or Connecticut Multispecialty Group, PC liable for any exacerbated condition that was not disclosed in the above questionnaire.

Signature: _____ Date: _____