Moments of Tranquility, LLC

Yoga & Bodywork Studio

Health Questionnaire

Name: ____ Date of Birth: __________________ Sex: Male Female
(Last) (First) (Middle initial) (Please circle one)

Address: ____ City: ______________________ State: ______ Zip: _________

Home Phone: _____________________ Work Phone: _____________________ Email: ______________________________

Occupation: _______________________________ Sports/Hobbies: ____

May we contact you at home? _____ Yes _____ No May we contact you at work? _____ Yes _____ No

In case of an emergency, contact Name: ______________________________________ Phone: ____________________

Were you referred to this office? _____ Yes _____ No Name: ____

Internet: _____ Yellow pages: _____ Ad: _____ Sign:_____ Other:_____ Please specify: _________________________

Please circle the following symptoms or conditions you have **now** or have had **previously:**

Allergies	Heart Disease/Heart Attack	Poor Circulation	Lumps in Breasts/Chest
Arthritis	High Blood Pressure	Shoulder Pain	Mammary Fibrocysts
Cancer	Low Back Pain	Skin Problems	Menopausal Syndrome
Diabetes	Multiple Sclerosis	Stroke	Premenstrual Syndrome
Dizziness	Neck Pain	Tuberculosis	Pregnant, How long? ___________
Epilepsy	Nervousness/Depression	Ulcers	Recent Births
Fibromyalgia	Numbness	Varicose Veins	Digestive Disturbance
Headaches	Polio	Edema	Alcohol/Drug Dependency

Please list any serious illnesses or injuries not listed above (i.e. diagnosis): ________________________________

Please list any surgeries and the approximate date: ____

Are you presently under medical, chiropractic, naturopathic care? ____ Yes ____ No Date last seen: ______________

Name of primary physician: ____ Phone: _________________________

May we have permission to consult your primary physician? _____Yes _____No (initial if yes) ___________

List any prescription and non-prescription medications, vitamin, or mineral supplements or other remedies that you are taking: ____

---

1. Have you ever had a professional massage before? _____ Yes _____ No Regularly? _____ Yes _____ No
2. What would you like to learn or achieve through massage therapy? Check all that apply:
   - _____ Increase self-awareness
   - _____ Reduce stress
   - _____ Overall relaxation
   - _____ Relieve specific areas of discomfort ____
   - _____ Enhance athletic performance in ____
   - _____ Other ____
3. How would you rate your overall health? _____ Excellent _____ Good _____ Fair _____ Poor

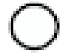
I understand that massage therapy is not intended to be a substitute for proper medical counseling. My therapist has not expressed or implied that massage is the primary treatment for any specific illness or disease. I understand that massage is an adjunctive therapy that can be coordinated with the advice, treatment, or prescriptions recommended by my regular physician. The decision to receive massage is left to my own discretion.

Signature:____ Date: ___________________

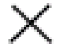
(See reverse side)

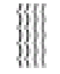
Please identify current problem areas in your body by drawing the appropriate symbols on the diagrams below:

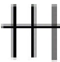
Key:

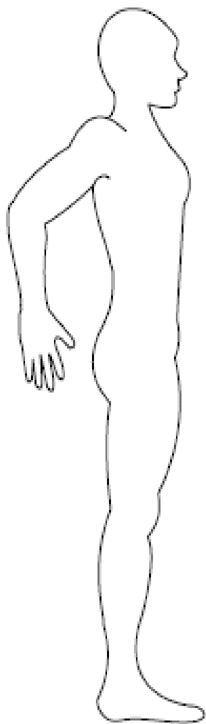
 Circle areas where **pain** exists

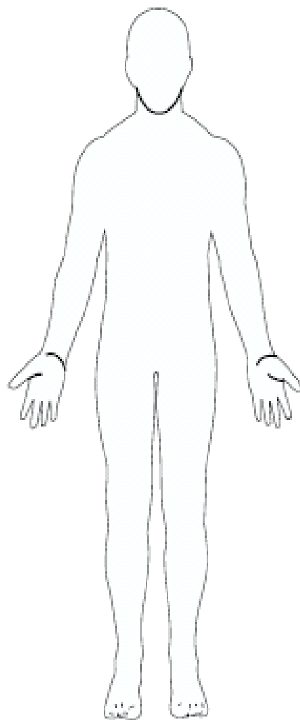
Circle areas where **extreme pain** exists

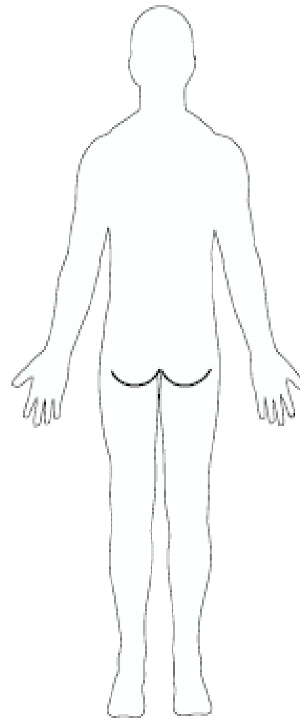
 Put an “X” over **stiff** areas

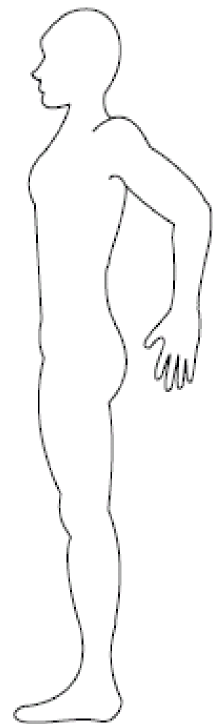
 Draw wavy lines over areas of **numbness** or **tingling**

 Mark **scars, bruises** or **wounds**


Right


Front


Back


Left

Comments: ____

____

____

____

____

____