



**Laura
Phillips, LMT LLC**

HEALTH QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ (H,W,C) E-mail address: _____

Occupation: _____ What brings you here: _____

Emergency Contact: _____ Phone: _____

How did you hear about me?: _____

*Have you received massage therapy in the past? Y / N Date last Received: _____

*Are you on any medications (List them)? _____

*What is your goal/focus for massage? _____

***Please circle the condition/s that you have now or had experienced in the past & add comments to clarify . *If you have a specific medial condition or symptom, receiving or performing massage may be contraindicated or require modification. A referral from your primary care provider may be requested prior to receiving &/or performing massage.**

Integumentary System (Skin)

- Boils
- Fungal infections
- Herpes Simplex
- Warts/moles
- Eczema
- Psoriasis
- Skin Cancer
- Skin allergies
- Rashes
- Burns
- Severe Sunburn
- Scars
- Cosmetic surgery
- Bruise easily
- Other: _____
- Comments: _____

Circulatory / Lymph / Endocrine System

- Anemia
- Phlebitis
- Heart disease/condition
- High Blood Pressure
- Low Blood Pressure
- Varicose Veins
- Diabetes
- Clotting disorders
- Edema
- Hodgkin's disease
- AIDS, HIV
- Chronic Fatigue Syndrome
- Lupus
- Cold/flu/fever (Currently)
- Hypo/Hyperthyroidism
- Leukemia/lymphoma
- Other: _____
- Comments: _____

Respiratory System (Breathing)

- Sinus problems
- Tuberculosis
- Asthma
- Emphysema
- Other: _____
- Comments: _____

Musculoskeletal System (Muscle)

- Fibromyalgia
- Rheumatoid Arthritis
- Osteoarthritis
- TMJ dysfunction
- Strains, sprains, tendonitis
- Bursitis
- Carpal tunnel syndrome
- Thoracic outlet syndrome
- Cramping, spasms, soreness
- Broken or fractured bones
- Persistent pain
- Loss of motion or mobility
- Difficulty with prolonged stance
- Unable to comfortably lie on both sides
- Other: _____
- Comments: _____

Digestive / Urinary System

- Cirrhosis
- Ulcer
- Gallstones
- Hepatitis
- Irritable Bowel Syndrome
- Kidney stones
- Reflux esophagitis
- Bladder infection
- Eating disorder
- Other: _____
- Comments: _____

Nervous System

- Multiple Sclerosis
- Spinal cord injury
- Brain injury
- Numbness/tingling
- Headaches
- Stroke
- Seizure disorder
- Reduced sensation
- Other: _____
- Comments: _____

Reproductive System

- Breast Cancer
- Ovarian cysts
- Painful Menstruation
- Pregnant # weeks _____
- Prostate Cancer
- Pelvic Inflammatory Disease
- Other: _____
- Comments: _____

Other

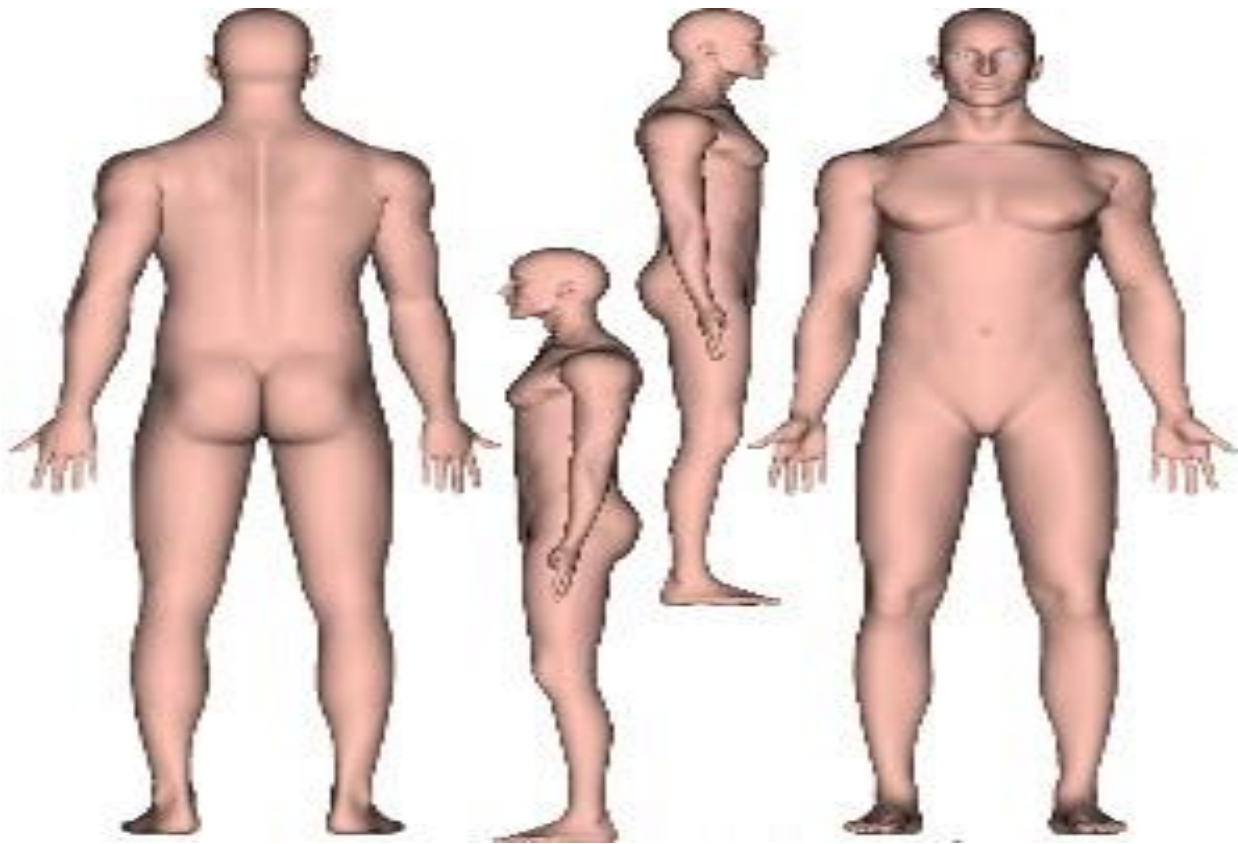
- Hearing impaired
- Visually impaired
- Insomnia
- Cancer (Other than specified above)
- Alcoholism/substance abuse
- Heavy caffeine or nicotine user
- Physical abuse
- Psychological condition
- Using over the counter medication
- Accidents: _____

• Surgery other than specified above: _____

Other conditions: _____

Comments: _____

Indicate any areas that you feel discomfort:



Please list any restrictions that you are experiencing: _____

I have stated all conditions that I am aware of and that this information is true and accurate to the best of my knowledge. I agree to inform my massage therapist immediately of any change in conditions as stated above. Massage Therapy is not intended to substitute proper medical care, nor is it used for sexual purposes. I acknowledge that this information is confidential and may only be utilized by Laura Phillips, LMT LLC to provide you with the best care. I release Laura Phillips, LMT LLC from any unforeseen liability that may occur from receiving massage therapy. Laura Phillips, LMT LLC reserves the right to refuse service to anyone, at any time, for any reason. If the client is under the age of 18, a parent or guardian will be required to sign as consent to receive care.

Signature: _____ **Date:** _____