# Eastlake Massage Health Questionnaire

**Part I**

Name:______________________________________ DOB:________________________

**Part II** (If you've given this information to another practitioner in this office, please skip to Part III.)

Address:_________________________________City:_______________Zip:__________

Phone (H):______________________________ (W):______________________

Occupation:___________________________________ Marital Status:____________

Email Address:_______________________________________

**Part III**

Have you received massage before?_______Yes _______No
If yes, when?_________________ What type?________________________________________

Do you have any tender-to-touch areas?_____Yes _______No
If yes, where?____________________________________________________________

Are you receiving any medical, homeopathic or chiropractic care? _______Yes _______No

Are you currently taking any medications? _______Yes _______No
If yes, please list:_________________________________________________________

Are you currently experiencing any of the following?
_______ Pregnancy, trying to get pregnant _______Flu or cold _______Infection
_______ Inflammation or sunburn _______ Contagious disease _______Fever
_______ Sleep difficulties

Do you exercise regularly? ______Yes _______No

Do you have a history of the following?
_______ AIDS _______ Epilepsy/Seizures _______ Numbness
_______ Allergies _______ Excema _______ Phlebitis
_______ Arthritis _______ Headaches _______ Ringworm
_______ Bursitis _______ Heart Attack _______ Sciatica
_______ Cancer _______ High Blood Pressure _______ Varicose Veins
_______ Circulatory Problems _______ Insomnia _______ Whiplash
_______ Disc Problems _______ Low Blood Pressure

What areas would you like to work on in today's session and what would you like achieve?____________

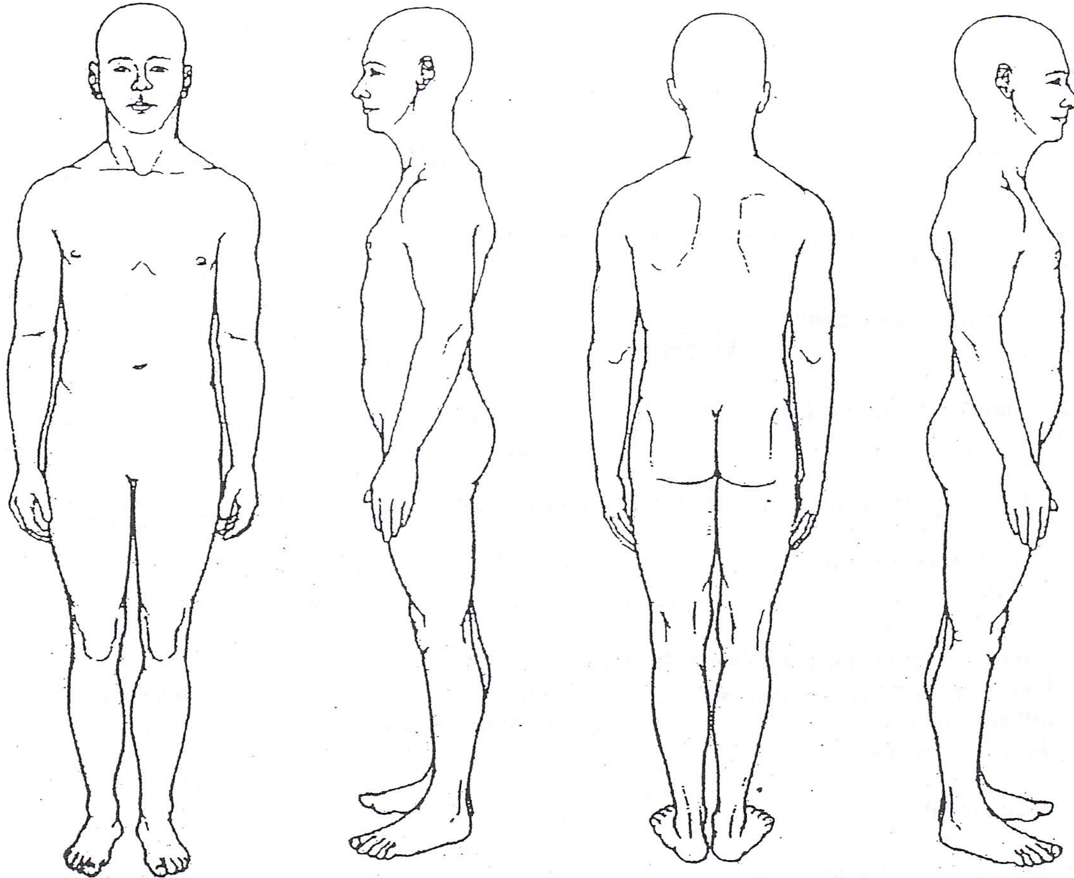
__________________________________________________________________________

__________________________________________________________________________

Continued on the following page

Please identify the CURRENT symptomatic areas in your body by marking the figure below. (See key.) Then circle the area around each letter representing the size and shape of the affected areas.

KEY:
P= Pain or tenderness
S= Joint or muscle stiffness
N= Numbness or tingling



Please read and sign the following:

- **I understand that massage is not a replacement for a doctor's care and that no diagnosis will be made.**

- **I authorize___________________________, LMP, to release information concerning my medical records and/or copies of my medical records to my insurance company for the purpose of applying for benefits.**

- **I am responsible for full payment of any appointment, no-show, or cancellation with less that 24 hours notice. If it becomes necessary to retain a collection agency, I agree to pay any fees associated with that service.**

_____________________________________ ____________________

Client Signature Date