

Body Sage Massage Therapies MEDICAL INFORMATION QUESTIONNAIRE

(Please Print)

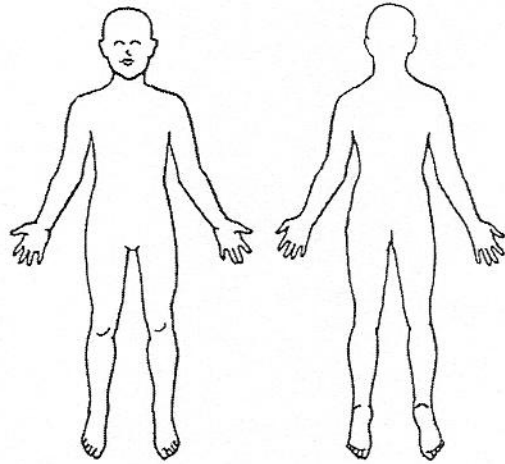
Today's Date: _____			
Patient's Last Name: _____	First: _____	MI: _____	Home Phone #: _____ () _____

Have you ever had a professional massage? Yes No

How often do you receive massage therapy and/or when was your last massage? _____

What is the main reason for your visit today? _____

Using this chart, please mark any areas of discomfort, tingling, aching, spasms, stiffness, numbness, dysfunction or preferred areas of focus and describe below:



Please check Yes or No to the following questions, and explain if necessary?

- | | | |
|--------------------------|--------------------------|-----------------------------------|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you feeling well today? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin disorders? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Any recent injuries? _____ |

Have you ever been diagnosed with ANY of the following conditions?

- | | | |
|--------------------------|--------------------------|---------------------------------|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | High/Low Blood Pressure? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Spinal Conditions? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Currently Pregnant? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other medical conditions? _____ |