# Client Health Questionnaire

Date:_____

## *General Information:*

Name: First_____ Last_____Date of Birth:_____

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

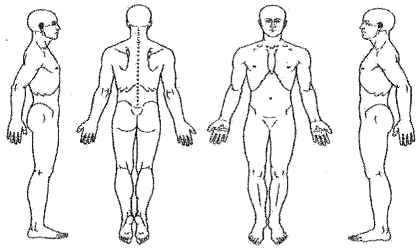
Phone: Hm_____ Wk/Cell_____ Occupation_____

E-mail:_____ Permission to communicate with you using this email acct. O Yes O No

Emergency Contact:_____ Phone: Hm/Cell_____

## *Health Information:*

Are you here today for pain relief? O Yes O No If yes, indicate location of pain using the images below:



What is the level of your pain? 0 1 2 3 4 5 6 7 8 9 10

How often do you feel your pain?
1. Intermittently 2. Occasionally 3. Frequently 4. Constantly

Please indicate the nature of your pain:
1. Numb 4. Shooting
2. Dull Ache 5. Burning
3. Sharp 6. Tingling

Any injuries?
O New (less than 5 yrs)
O Old (more than 5 yrs)
Please explain:_____

What caused your pain? 1. Overuse 2. Fall 3. Exercise 4. Accident 5. Other_____

Is there a physician treating you now? O Yes O No Physician name:_____

How would you describe your overall health? 1. Excellent 2. Good 3. Fair 4. Poor

Exercise of choice:_____ Frequency:_____

Are you currently taking any medication? O Yes O No Please explain: _____

_____

Do you have, or have you ever been diagnosed with, any of the following health conditions?

| | | | |
|---|---|---|---|
| Y N headaches/migraines | Y N skin conditions | Y N cancer | Y N insomnia |
| Y N varicose veins | Y N Scoliosis | Y N heart problems | Y N whiplash |
| Y N chronic pain | Y N HIV/AIDS | Y N high blood pressure | Y N arthritis |
| Y N hemophiliac | Y N abdominal cramps | Y N Stroke | |
| Y N constipation | Y N blood clotting | Other_____ | |

I understand that the services offered are not a substitute for medical care and that any information provided by the therapist is for educational purposes only and is not diagnostic or prescriptive in nature. If I experience any pain or discomfort I will immediately inform the therapist so the pressure and/or technique can be adjusted to my level of comfort. Because massage should not be performed under certain medical conditions I affirm that I have stated all of my known medical conditions. I agree to actively participate as much as possible in my own healing.

Client Signature: _____ Date: _____

*Consent to treat minor:* By my signature below, I hereby authorize Joe Sweeney NCTMB to administer massage and bodywork therapy techniques to my minor child or dependent.

Parent or Guardian Signature: _____ Date: _____