MONROE THERAPEUTIC MASSAGE

CONFIDENTIAL HEALTH SCREENING QUESTIONNAIRE FOR MASSAGE

Date ________________________ How did you learn about us? ______________________________

Last Name ______________________________ First Name ____________________________ M.I. ________

Street Address _______________________________________ City ______________________ Zip _________

Phone: Hm ______________________________ Wk ________________________ Cell __________________

Occupation/Activities ____

Date of Birth ____________________________ Age ___________ Sex: ☐ F ☐ M

**** I have been given and read the HIPAA information for Monroe Therapeutic Massage, PS. ****

Signature: **Date:**

Have you ever experienced any of the following? Please used '**C**' for current, '**P**' for past, '**S**' for sometimes

__ HIV/AIDS	__ Constipation	__ Herpes	__ Sciatica
__ Allergies	__ Diarrhea	__ High Blood Pressure	__ Stiff Joints
__ Anemia	__ Diabetes	__ Low Blood Pressure	__ Skin Allergies
__ Athletes Foot	__ Digestive Problems	__ Insomnia	__ Sprains/Strains
__ Arthritis	__ Disc Problems	__ Excess Stress	__ Stroke
__ Back Pain	__ Diverticulitis	__ Migraines	__ Swollen Feet/Legs
__ Bone Fractures	__ Eczema	__ Muscle Spasms	__ Tendonitis
__ Bursitis	__ Epilepsy/Seizures	__ Numbness	__ Tingling
__ Cancer	__ Fibromyalgia	__ Phlebitis	__ Tumors
__ Chronic Fatigue	__ Headaches	__ Psoriasis	__ Varicose Veins
__ Circulatory Problems	__ Heart Attack/Ailments	__ Rashes	__ Whiplash
__ Colitis	__ Hemophilia	__ Ringworm	__ Other ______________

For Women only:			
	__ Pregnant	__ Excessive Bleeding	__ Menstrual Cramps
	__ Trying to be Pregnant	__ Amenorrhea	__ PMS

Accidents, Injuries or Surgeries:

Less than 5 years ago ____

More than 5 years ago ____

Are you currently receiving medical or chiropractic care? ☐ Yes ☐ No

If yes, please explain ____

Are you taking any medications (prescription & over-the-counter)? ☐ Yes ☐ No

If yes, please explain ____

Why have you come for massage? ____

Have you received massage before? ☐ Yes ☐ No

Please read and sign the following:

I acknowledge that the above information is complete and accurate to the best of my knowledge and that I will notify Monroe Therapeutic Massage, P.S. and/or treating LMP of any changes in my physical condition prior to massage.

I am also aware that payment is due on the date of service.

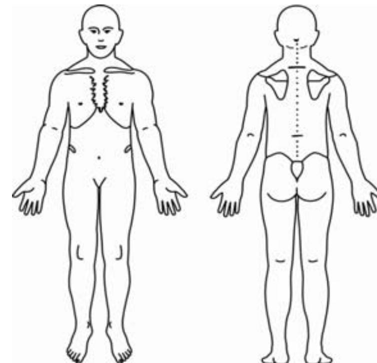
A missed appointment or cancellation with less than 24 hours notice will be charged $35.00.

______________________ ______________

Signature **Date**

Please circle areas of pain/stress/tension

"**X**" areas you do <u>not</u> wish to be touched; genitals are never touched.



11/09

YOU MUST SIGN BOTH BOXES!