**Maitri Massage LLC Therapy Questionnaire**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Initial Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of an Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1) Have you ever had Massage Therapy before? Yes\_\_\_\_\_ No\_\_\_\_\_ If so, when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) Do you have difficulty lying on your front, back, or side? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

3) Do you have allergic reactions to oils, lotions, ointments, liniments, or other substances put on your skin? Yes\_\_\_\_\_ No\_\_\_\_ If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4) Do you wear contact lenses ( ), dentures ( ), a hearing aid ( ) ?

5) Do you experience stress in your work, family, or other aspects of your life? Yes\_\_\_\_ No\_\_\_\_

How would you describe your stress level? Low\_\_\_ Medium \_\_\_ High \_\_\_\_ Very High \_\_\_\_

If high, how do you think your stress has affected your health? Muscle Tension ( ), Anxiety ( ), Insomnia ( ), Irritability ( ), Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6) What is your major complaint, if any that you want to improve? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7) When did you first notice this complaint? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8) What event(s) brought it on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9) What activities aggravate the condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10) What have you done to get relief? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11) Are you currently under medical supervision? Yes\_\_\_ No\_\_\_

12) Are you currently taking any medications? Yes \_\_\_ No \_\_\_ If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

**Musculo-Skeletal Skin Reproductive System**

\_\_\_Headaches \_\_\_Rashes \_\_\_Pregnancy

\_\_\_Joint stiffness/swelling \_\_\_Allergies \_\_\_Current \_\_\_Previous

\_\_\_Spasms/cramps \_\_\_Athlete's Foot \_\_\_PMS

\_\_\_Broken/fractured bones \_\_\_Warts \_\_\_Menopause

\_\_\_Strains and sprains \_\_\_Moles \_\_\_Pelvic inflammatory disease

\_\_\_Back, hip pain \_\_\_Acne \_\_\_Endometriosis

\_\_\_Shoulder, neck, arm, hand pain \_\_\_Cosmetic Surgery \_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Leg, foot pain \_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Chest, ribs, abdominal pain

\_\_\_Problems walking

\_\_\_Jaw pain/TMJ **Digestive Other**

\_\_\_Tendonitis \_\_\_Nervous stomach \_\_\_Cancer\_\_\_current\_\_\_remission

\_\_\_Bursitis \_\_\_Indigestion \_\_\_Diabetes

\_\_\_Arthritis \_\_\_Constipation \_\_\_Depression

\_\_\_Osteoperosis \_\_\_ Diarrhea \_\_\_Drug Use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Scoliosis \_\_\_ Diverticulitis \_\_\_Alcohol Use\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Bone or Joint Disease \_\_\_ IBS \_\_\_Nicotine Use\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Fibromyalgia \_\_\_ Crohn's Disease \_\_\_Caffeine Use\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Other \_\_\_ Adaptive aids \_\_\_Hearing Impairment

\_\_\_Other\_\_\_\_\_\_\_\_\_\_ \_\_\_Visual Impairment

\_\_\_ Infectious Disease\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circulatory and Respiratory**

\_\_\_Dizziness/lightheadedness

\_\_\_Shortness of breath **Nervous System**

\_\_\_Fainting \_\_\_Numbness/tingling

\_\_\_Cold feet or hands \_\_\_Twitching of face

\_\_\_Lymphedema \_\_\_Fatigue

\_\_\_Swollen ankles \_\_\_Chronic pain

\_\_\_Pressure sores \_\_\_Sleep Disorders

\_\_\_Varicose veins \_\_\_Ulcers

\_\_\_Blood clots \_\_\_Paralysis

\_\_\_Stroke \_\_\_Herpes/shingles

\_\_\_Heart condition \_\_\_Spinal cord injury

\_\_\_Cerebral Palsy \_\_\_Epilepsy

\_\_\_Sinus problems \_\_\_Chronic Fatigue Syndrome

\_\_\_Asthma \_\_\_Multiple Sclerosis

\_\_\_High Blood Pressure \_\_\_Muscular Dystrophy

\_\_\_Low Blood Pressure \_\_\_Parkinson's Disease

\_\_\_Diabetes \_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any additional comment regarding your health and/or surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POLICIES**

Draping will be used during the session. Only the area being worked will be uncovered.

a.) I understand that 24 hours’ notice is required for cancellation of an appointment, and that a fee of

50% of the cost of the scheduled service may be charged to me when this courtesy is not provided.

Initial \_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b.) I understand that: I am to arrive 10 min before my scheduled appointment. (This allows you ample time to use the facilities, turn off your cell phone and relax before your session. You are here to relax and recover.) Initial \_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c.) I understand that I am to notify my massage therapist of any changes in my health care/Medical History. Initial \_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Massage increases circulation of lymph, blood and oxygen. It has been shown to greatly reduce stress, tension and pain. Massage can aid in better mood, increased energy and induce a more restful night’s sleep. If you are seeking a massage for any other purpose such as a chronic pain condition, please list the conditions for which you wish to seek massage therapy:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print your name) confirm all of the above information provided is correct to the best of my knowledge. I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension and is not intended to diagnose or treat any condition that I may have. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical adjustments, diagnose, prescribe or treat any physical or mental illness. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there is no liability on the therapist’s part should I fail to do so. In the event that I become injured either directly or indirectly as a result, in whole or in part of the aforesaid massage therapist I HEREBY HOLD HARMLESS AND INDEMNIFY the therapist and her principals and agents from all claims and liability whatsoever.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Massage Client

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maitri Massage Representative