

MESSAGE THERAPY QUESTIONNAIRE – WOMAN’S HOSPITAL OF TEXAS

Name: _____ Physician: _____ Date: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell _____

1. What problem has brought you to massage therapy? _____

2. MEDICAL HISTORY: (Check all conditions that apply to you)

HEART CIRCULATION	√	PAIN	√	MEDICAL CONDITIONS	√	BOWEL/BLADDER	√
Heart Disease		No Pain Anywhere		Diabetes		Constipation	
High Blood Pressure		Feet		Fainting Spells		Diarrhea	
Stroke		Knees		Dizziness		Hemorrhoids	
Pacemaker		Hips		Kidney Disease		Urinary Leakage	
Heart Surgery		Shoulders		Thyroid Problems		Irritable Bowels	
Discomfort in Chest		Abdomen		Cancer		FAMILY HISTORY	√
Angina		Back Pain		Depression/anxiety		Heart Disease	
High cholesterol		Neck Pain		Visual impairment		Stroke	
High Triglycerides		Arms		Hearing impairment		High Blood Pressure	
Ankle Swelling		Legs		Clogged sinuses		Diabetes	
BONES & JOINTS	√	SKIN PROBLEMS	√	LUNGS	√	OB/GYN HISTORY	√
Osteoporosis		Dermatitis		Difficulty breathing		FOR WOMEN ONLY	
Scoliosis		Eczema		Cigarette smoker		ARE YOU PREGNANT?	
Fibromyalgia		Allergy to lotions		History of smoking		Pelvic Pain	
Arthritis		Hives		Labored Breathing		Menstrual Pain	
Dropped Arches/Feet		Other skin allergies		Lung Problems		PMS	
Joint Replacements				Shortness of breath		Hysterectomy Abdominal	
						C-Section	
HAVE YOU HAD A MESSAGE BEFORE? __Yes __No				SURGERIES/date	√	Laparoscopic Surgery	
If yes, please describe what you liked or did not like				Back		Scar Pain/Stuck Scar	
				Neck		Hormone Replacement	
				Knee			
				Abdominal			
				Hip			

3. MEDICATIONS

NAME OF MEDICATION	PURPOSE	NAME OF MEDICATION	PURPOSE

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4. PSYCHOSOCIAL

Marital Status: Married Single Widowed (er) Divorced Separated

Educational Level _____ Occupation: _____ Hobbies: _____

What type of exercise are you doing now?

CHECK THE WORDS THAT APPLY TO HOW YOU FEEL THESE DAYS

<input type="checkbox"/> Happy	<input type="checkbox"/> Calm	<input type="checkbox"/> Unmotivated	<input type="checkbox"/> Stressed	<input type="checkbox"/> Lonely	<input type="checkbox"/> Content	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Overwhelmed	<input type="checkbox"/> Sad	<input type="checkbox"/> Tired	<input type="checkbox"/> Afraid	<input type="checkbox"/> Energetic	<input type="checkbox"/> Optimistic	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Flabby	<input type="checkbox"/> Strong	<input type="checkbox"/> Un-rested	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Weak	<input type="checkbox"/> Overworked	<input type="checkbox"/>	<input type="checkbox"/>

5. What Areas of your Body do you specifically want us to **focus on** during your massage?

Arms Legs Back Neck Belly Buttocks Other _____

6. *Breasts and the Genital areas will not be massaged. What other areas of your body do you prefer we avoid during Massage?* _____

7. FLUID INTAKE: What do you drink every day?

Glasses of water cans of diet soda cans of regular soda cups of regular/decaf coffee
 Glasses of tea cans of beer glasses of wine glasses of milk other _____

8. WHAT ARE YOUR GOALS FOR MASSAGE THERAPY?

Lessen pain in my _____ Reduce tension/relieve stress
 Other _____

9. WHAT TYPE OF PRESSURE DO YOU PREFER? Light Firm/medium Deep

10. WHAT TYPE OF LUBRICANT DO YOU PREFER? Oil Lotion

11. WHAT TYPE OF FRAGRANCE DO YOU PREFER? No Scent Lavender _____

12. Are you on Bed Rest due to a medical Condition? Yes No

I voluntarily consent to massage therapy and understand that I may withdraw at any time.

Your signature & date

Therapists signature & date

Therapists Comments:
