Body Sage Massage Therapies (Please Print)

MEDICAL INFORMATION QUESTIONAIRE

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

Have you ever had a professional massage? ☐ Yes ☐ No

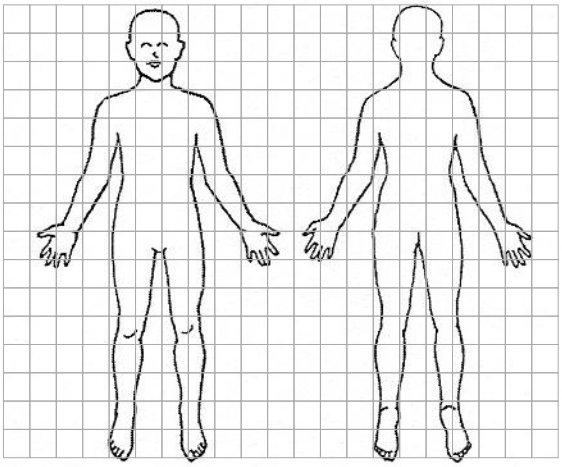
How often do you receive massage therapy and/or when was your last massage?_____

_____

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:



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

YES	NO		
☐	☐	Are you feeling well today?	_____
☐	☐	Skin disorders?	_____
☐	☐	Allergies?	_____
☐	☐	Any recent injuries?	_____

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

YES	NO		
☐	☐	Arthritis?	_____
☐	☐	High/Low Blood Pressure?	_____
☐	☐	Heart Disease?	_____
☐	☐	Diabetes?	_____
☐	☐	Cancer?	_____
☐	☐	Spinal Conditions?	_____
☐	☐	Currently Pregnant?	_____
☐	☐	Other medical conditions?	_____