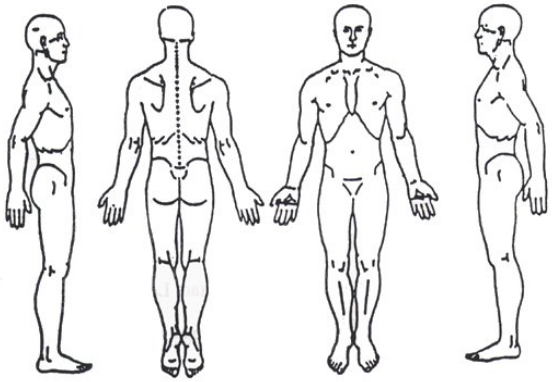
ABBOTT FAMILY CHIROPRACTIC, PC

Hampton, VA Hayes, VA

Massage Questionnaire

Name: _____ **Date:** _____

1. Have you had a professional massage before? **Yes** **No**
   If yes, how often do you receive massage therapy?_____
2. Do you have any difficulty lying on your front, back or side? **Yes** **No**
   If yes, please explain. _____
3. Do you have any allergies to oils, lotions, or ointments? **Yes** **No**
   If yes, please explain. _____
4. Do you have sensitive skin? **Yes** **No**
5. Are you wearing contact lenses **( )** dentures **( )** a hearing aid **( )** ?
6. Do you sit for long hours at a workstation, computer, or driving? **Yes** **No**
   If yes, please describe. _____
7. Do you perform and repetitive movement in you work, sports, or hobby? **Yes** **No**
   If yes, please describe. _____
8. Do you experience stress in your work, family, or other aspect of your life? **Yes** **No**
   If yes, how do you think it has affected your health?
   Muscle tension **( )** Anxiety **( )** Insomnia **( )** Irritability **( )** Other _____
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort? **Yes** **No**
   If yes, please identify. _____
10. Do you have any particular goals in mind for this massage session? **Yes** **No**
    If yes, please explain. _____



Circle any specific areas you would like the massage therapist to concentrate on during the session:

11. Are your currently under medical supervision? Yes No

    If yes, please explain. _____

12. Do you see a chiropractor? **Yes** **No**

    If yes, how often? _____

13. Are you currently taking any medications? **Yes** **No**

    If yes, please list. _____

14. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) neck pain
( ) back pain
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains / strains
( ) current fever
( ) swollen glands
( ) allergies / sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) aneurysm
( ) toxic edema
( ) lung disease
( ) sclerosis
( ) joint disorder / rheumatoid arthritis / osteoarthritis / tendonitis

( ) acne
( ) phlebitis
( ) deep vein thrombosis / blood clots
( ) osteoporosis
( ) epilepsy
( ) headaches / migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back / neck problems
( ) fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) athlete's foot
( ) kidney inflammation
( ) asthma
( ) hernia
( ) HIV/AIDS
( ) emotional changes
( ) pregnancy
If yes, how many weeks?

Please explain any condition that you have marked above. _____

_____

_____

15. Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? _____

_____

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