WELLSTAR Health Place

Massage Therapy Services
Health History Questionnaire

Name: _____ DOB: _____
Last First Middle

Member _____ Non Member _____

Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Business Phone: _____
Occupation: _____
Emergency Contact: Name _____
Relationship: _____
Phone Number: _____

Do you wear contacts? _____ Hearing Aid? _____

In the last year have you:
Had an operation? _____ Please describe: _____
_____
Broken any bones? _____ Please describe: _____
_____
List any medications that you are currently taking:
_____
_____
Doctor's name and phone #:

_____

Please check if you have, or have ever had, any of the following in the last three years:

___Abdominal Pain
___AIDS
___Arthritis
___Cancer
___Chronic Fatigue Syndrome
___Colitis
___Diabetes
___Dizziness
___Epilepsy
___Fibromyalgia
___High Blood Pressure
___Low Blood Pressure
___Migraines
___Painful Urination
___Phlebitis
___Pleurisy
___Sciatica
___Scoliosis
___Shortness of Breath
___Skin Irritations
___Thyroid
___TMJ Dysfunction
___Varicose Veins
___Other

If other, please explain: _____

Are you Pregnant? _____ How many months? _____ Using Midwife? _____
Obstetrician's name and phone #: _____

Signature: _____ Date: _____

Referred by: _____