Sycamore Day Spa Massage Questionaire

Thank you for giving us the opportunity to service you! Please take the time to fill out the following information about yourself.
This information will help us give you better care and enable me to provide a safe service for you. All client information is kept confidential.

Name: _____ _____ Date of Birth:_____/_____/_____
First Last

Address: _____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Other Phone:_____

Email: _____ Do you want to receive an email appt reminder 1-2 days before your appt? Yes or No
We do not sell or give out your email

Whom may we thank for referring you?:_____

Massage Questionaire

Have you ever received a massage before? ☐ Yes or ☐ No Type & Frequency:_____

Do you have any questions about Massage Services?_____

_____

Reason for today's visit:_____

Is there a certain way you like your Massage? Deep, Light, Firm, etc._____

What do you look for in a Massage Therapist?_____

_____

Current Health Information

PCP Name: _____ Phone:_____

An Emergency Contact Name:_____Relationship: _____Emergency Contact Number(s):_____

List all conditions currently monitored by a Health Care Provider:_____

_____

List all medications that you currently take (including pain relievers & herbal remedies):_____

_____

List Daily Activities

Work:_____

Home/Family:_____

Social/Recreational:_____

Stress Reduction/Exercise Activities:_____Frequency:_____

Your Past Year Health History (list in chronological order, give dates or age when occurred and treatment received)

Surgeries (including cosmetic) :_____

Accidents:_____

Major Illnesses:_____

Turn Over ----->

Check all current and previous conditions only within the PAST YEAR from today:

GENERAL:

Condition

- ☐ Headaches
- ☐ Pain
- ☐ Sleep Disorders
- ☐ Fatigue
- ☐ Infection
- ☐ Fever
- ☐ Sinus
- ☐ Pregnancy
- ☐ Other:_____

SKIN CONDITIONS:

Condition

- ☐ Athlete's Foot
- ☐ Warts
- ☐ Eczema or Psoriasis
- ☐ Other:_____

MUSCLES & JOINTS:

Condition

- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ TMJ, Jaw Pain
- ☐ Broken Bones:_____
- ☐ Spinal Problems
- ☐ Disk Problems
- ☐ Sprains, strains
- ☐ Tendonitis, bursitis
- ☐ Spasms, cramps
- ☐ Stiff, painfull joints
- ☐ Weak and sore muscles
- ☐ Neck, Shoulder, arm pain
- ☐ Low Back, Hip, Leg pain
- ☐ Other:_____

LUNGS & HEART:

Condition

- ☐ Heart Disease
- ☐ Blood Clots
- ☐ Stroke
- ☐ Lymphedema
- ☐ High, low blood pressure
- ☐ Irregular heartbeat
- ☐ Poor Circulation
- ☐ Swollen Ankles
- ☐ Vericose Veins
- ☐ Chest Pain
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Nausea
- ☐ Other:_____

ALLERGIES:

Condition

- ☐ Scents, lotions, oils
- ☐ Detergents
- ☐ Other:_____

NERVOUS SYSTEM:

Condition

- ☐ Head injuries, concussions
- ☐ Dizziness, ringing in ears
- ☐ Loss of memory, confusion
- ☐ Numbness, tingling
- ☐ Sciatica
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Chronic Pain:_____
- ☐ Other:_____

I have informed them of all my known medical conditions and answered all questions honestly. I understand that Sycamore Day Spa therapists will only use and/or disclose my personal health information (PHI) for the purposes of carrying out treatment and evaluating the quality of services provided. Client PHI information will never be sold/given outside of Sycamore Day Spa. I have freely disclosed this information and have accepted and received the aftercare plan. I agree to keep the therapist performing services on me at Sycamore Day Spa updated as to any changes in my medical profile and understand that there shall be no liability to Sycamore Day Spa should I fail to do so. I consent to receiving services by therapists at Sycamore Day Spa.

_____ _____ _____

Signature | Printed Name | Todays Date