Health Questionnaire
~ Serenity Massage & Energywork ~

Name_____ Date of Birth_____ Gender _____
(First) (Last)
Address_____ City _____State_____ Zip_____
Occupation_____
Phone_____E-mail_____Cell_____
How did you hear about our services?_____
Why are you here today? _____
Circle the following symptoms you have now or have had previously:

Arthritis High/Low Blood Pressure Neck/ Shoulder Pain Lumps in Breasts/Chest Nervousness
Cancer Low Back Pain Skin Conditions Stroke Recent Births
Dizziness Diabetes Tuberculosis Epilepsy Depression Lymphedma
Fibromyalgia Numbness Varicose Veins Digestive Disturbance Heart Condition
Edema (Swelling) Alcohol/Drug Dependency Diverticulitis Recent hemorrhage
Blood clots Dislocated bones/joints Bruise easily Allergies _____
Chronic pain Autoimmune condition TMJ disorder Circulation disorder
Insomnia Scoliosis Seizures Nervous system dysfunction

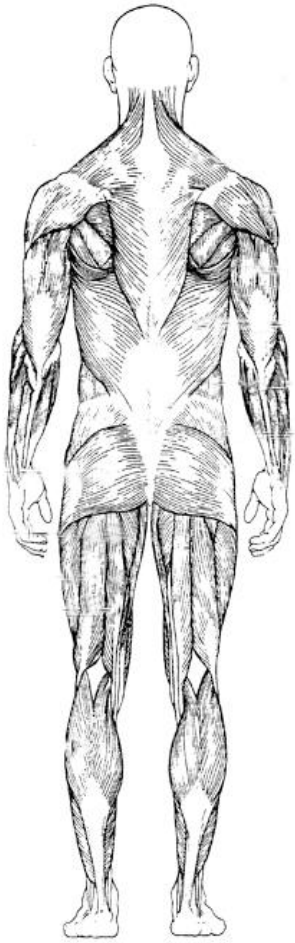
Are you Pregnant? How Long?_____
Abdominal complaint. Please specify_____
Do you have any of the following today?
Skin rash___ Cold/Flu___ Open cuts___ Severe pain___ Anything contagious___ Injuries/bruises_____

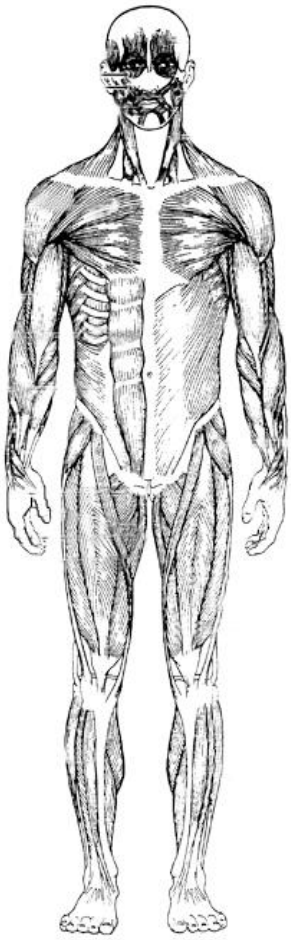
Please list any surgeries and the approximate date_____
Are you in recovery for addictions or abuse?_____
Name & Phone number of Primary Caregiver_____
Names of doctors, or other health care practitioners:
Name:_____Name:_____
Address: _____ Address:_____
Telephone:_____Telephone_____
List any prescription & non-prescription medications, vitamin or mineral supplements or other remedies that you are taking _____
In case of an emergency, contact Name_____Phone_____
Have you had a professional massage before? Yes__ No__ Regularly? Yes__ No__
How would you rate your overall health? __Excellent __Good __Fair __Poor

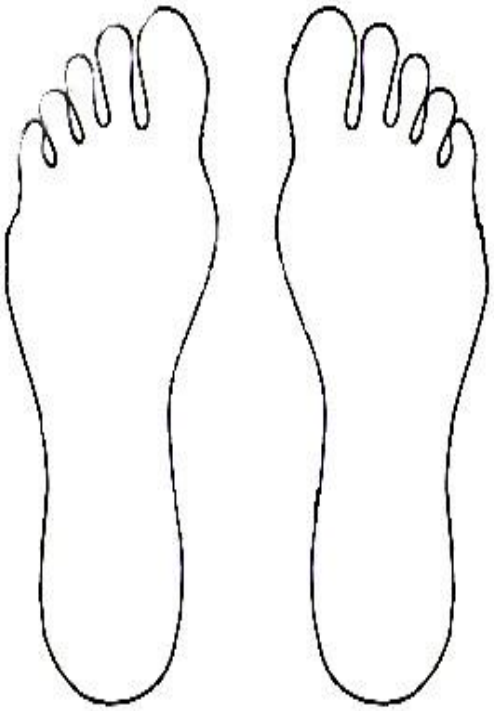
I understand that massage therapy is not intended to be a substitute for proper medical counseling. My therapist has not expressed or implied that massage is the primary treatment for any specific illness or disease. I have completed this health information form to the best of my knowledge. I understand that information exchanged during treatments is educational in nature and is only intended to help me become more aware of my own health status and is to be used at my own discretion and does not constitute professional medical advice and or diagnoses. I agree to update the therapist of any changes in my health profile. I release the therapist of any liability if I fail to do so. If I experience any discomfort or pain during treatment, I will immediately inform the therapist so that adjustments can be made to the treatment. I also understand that our time together is precious and I agree to cancel 24 hours in advance, unless there is an emergency. I understand that this is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.

Date_____Signature_____

Please indicate on the diagrams below, any areas of pain, stiffness or discomfort.







Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.
Signature of Parent or Guardian _____ Date _____