Massage By Carey Client Questionnaire

Personal Information

Basic Information

First Name

Last Name

Date of Birth (MM/DD/YYYY)

Male Female Not Specified

Occupation

Contact Information

Email

Phone (mobile preferred)

Cell

Address

City

State

Zip

Emergency Contact Information

Contact Name

Phone

Relationship

How did you hear about us?

Doctor (optional)

Physician Name

Phone

Issue(s) To Address Information

Cause of Injury or Concern

How long since first noticed

Describe your treatment goals

Past Treatment

Additional Questions

Describe exercise, repetitive activities or hobbies you have

Existing Conditions Information

Respiratory

- [ ] Asthma
- [ ] Bronchitis
- [ ] Chronic cough
- [ ] Emphysema
- [ ] Shortness of Breath

Cardiovascular

- [ ] Blood Clots
- [ ] Cardiovascular Accident
- [ ] Cerebral-vascular Accident
- [ ] Cold Feet
- [ ] Cold Hands
- [ ] Congestive Heart Failure
- [ ] Heart Attack
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Lymphedema
- [ ] Myocardial Infarction
- [ ] Pacemaker
- [ ] Phlebitis
- [ ] Stroke
- [ ] Thrombosis/Embolism
- [ ] Varicose Veins

Skin

- [ ] Bruise Easily
- [ ] Hypersensitive Reaction
- [ ] Melanoma
- [ ] Skin Conditions
- [ ] Skin Irritations

Head & Neck

- [ ] Ear Problems
- [ ] Headaches
- [ ] Hearing Loss
- [ ] Jaw Pain (TMJD)
- [ ] Migraines
- [ ] Sinus Problems
- [ ] Vision Loss
- [ ] Vision Problems

Infectious Conditions

- [ ] Athlete's Foot
- [ ] Hepatitis
- [ ] Herpes
- [ ] HIV
- [ ] Respiratory Conditions
- [ ] Skin Conditions

Women

- [ ] Gynecological Conditions
- [ ] Pregnancy

Soft Tissue / Joint Dysfunction

- [ ] Ankles (Left)
- [ ] Ankles (Right)
- [ ] Arms(Left)
- [ ] Arms(Right)
- [ ] Feet (Left)
- [ ] Feet (Right)
- [ ] Hands (Left)
- [ ] Hands (Right)
- [ ] Hips (Left)
- [ ] Hips (Right)
- [ ] Knees (Left)
- [ ] Knees (Right)
- [ ] Legs (Left)
- [ ] Legs (Right)
- [ ] Lower Back (Left)
- [ ] Lower Back (Right)
- [ ] Mid Back (Left)
- [ ] Mid Back (Right)
- [ ] Neck (Left)
- [ ] Neck (Right)
- [ ] Shoulders (Left)
- [ ] Shoulders (Right)
- [ ] Upper Back (Left)
- [ ] Upper Back (Right)

Family History

- [ ] Cardiovascular Conditions
- [ ] Respiratory Conditions

Miscellaneous

- [ ] Allergies
- [ ] Anaphylaxis
- [ ] Artificial Joints / Special Equipment
- [ ] Arthritis
- [ ] Cancer
- [ ] Crohn's Disease
- [ ] Digestive Conditions
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Diabetes
- [ ] Gout
- [ ] Hemophilia
- [ ] Insomnia
- [ ] Fibromyalgia
- [ ] Lupus
- [ ] Mental Illness
- [ ] Osteo Arthritis
- [ ] Loss of Sensation
- [ ] Other Diagnosed Diseases
- [ ] Other Medical Conditions
- [ ] Rheumatoid Arthritis
- [ ] Osteoporosis
- [ ] Shingles
- [ ] Stress
- [ ] Surgical Pins or Wire

Allergies and other conditions your provider should be aware of

Neurological

- [ ] Burning
- [ ] Cerebral Palsy
- [ ] Herniated Disc
- [ ] Multiple Sclerosis
- [ ] Numbness
- [ ] Parkinsons
- [ ] Stabbing pain
- [ ] Tingling

Medications Please list any medications or drugs you are currently on

Additional Questions

List any past surgeries or injuries you've had.