Massage Therapy Health Questionnaire

Danielle Wieczorek (402) 619-6910

Please Print

NAME (First and Last) _____

CELL PHONE # _____ LANDLINE# _____ WORK #_____

ADDRESS _____ CITY_____ STATE _____ ZIP _____

DATE OF BIRTH _____ AGE _____ EMAIL _____

OCCUPATION _____

*** REMINDER (Check one) TEXT _____ EMAIL _____ PHONE CALL_____

Please be advised that certain conditions may be contraindicated for therapeutic massage, and your session may need to be adjusted, discontinued, or rescheduled if massage would put your health or the health of the therapist at risk. Please review the following conditions and circle those that apply to you:

HIV/AIDS Tension Headaches/Migraines Joint Pain Anxiety/Depression Cancer

Carpel Tunnel Syndrome Muscle Pain Skin Conditions Heart Issues Arthritis

Gout High/Low Blood Pressure Diabetes Varicose Veins Allergies Cold/Flu

Please explain any of the conditions you have circled above:

_____

Medications currently taking: _____

Recent injuries or surgeries: _____

Do you have your physician's permission to receive therapeutic massage? Yes____ No ____ Not necessary ____

Are you pregnant? Yes _____ No _____ If yes, what is your expected due date_____

Massage Therapy is not intended to substitute proper medical care, nor is it used for sexual purposes. All information given is true to the best of my knowledge. I release Danielle Wieczorek from any unforeseen liability that may occur from receiving massage therapy. Additionally, I understand that by not showing up for three scheduled appointments, there will be a required prepayment for future appointments.

Signature _____ Date _____