Healthy Habits Therapeutic Massage
Healthy Habits Create Healthy Lives!
7002 Graham Rd Ste. 206
Indianapolis, IN 46220
Phone: (317) 434-4133

Appointment Details:
Date: _____ Time: _____
Service: _____ Length: _____

Health Questionnaire

Name_____ Date of Birth_____

Address_____City/State Zip_____

Phone _____ E-mail_____

Occupation_____ Primary reason for appointment_____

How did you find us? / Referred by _____ Previous experience with bodywork (massages) Yes / No

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Please check all conditions that apply now, or in the past, and give details below:

- ○ **Allergies, sensitivities Yes / No**
- ○ **Arthritis / tendonitis Yes / No**
- ○ **Blood clots Yes / No**
- ○ **Cancer, tumors Yes / No**
- ○ **Chronic pain Yes / No**
- ○ **Headaches (how often?) Yes / No_____**
- ○ **Injuries Yes / No**
- ○ **Joint pain Yes / No**
- ○ **Muscle pain (neck/back/shoulder,…) Yes / No**
- ○ **Numbness / tingling Yes / No**
- ○ **Skin allergies Yes / No**
- ○ **Sprains / strains Yes / No**
- ○ **Carpel tunnel Yes / No**
- ○ **Constipation / diarrhea Yes / No**
- ○ **Head injuries Yes / No**
- ○ **Heart / lung conditions Yes / No**
- ○ **High / low blood pressure Yes / No**
- ○ **Depression Yes / No**
- ○ **Diabetes Yes / No**
- ○ **Fatigue Yes / No**
- ○ **Infectious diseases Yes / No**
- ○ **Rashes / athletes foot Yes / No**
- ○ **Sleep difficulties Yes / No**
- ○ **Sinus problems Yes / No**
- ○ **Varicose veins Yes / No**
- ○ **Other conditions Yes / No**
- ○ **Currently on mediations Yes / No**

Females:

- ○ **Pregnancy Yes / No**
- ○ **Menstrual cycle Yes / No**

Do you have any other conditions of which I should be aware, including surgeries and accidents? If yes, please explain

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I understand that the bodywork given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow. I understand that the therapists do not diagnose illness, or disease, nor do they prescribe any medical treatments. I acknowledge that bodywork is not a substitute for medical examination or diagnosis, and it is recommended that I see a health care provider for that service. I have stated all medical conditions and will update the practitioner with any changes in my health status on subsequent visits.

Signature_____ Date_____