PRAIRIE SPA

Massage Experience

1. Have you had a professional massage before? ◯Yes ◯No
If yes, what types of massage have you had (Swedish, Deep Tissue, etc.)? _____
_____
2. How long have you been receiving massage therapy? _____
3. Frequency of massage? _____
4. What are your goals for treatment? _____
_____

Current Health

- Reason for initial visit? _____
_____
- Height & Weight? _____
- Do you exercise regularly and /or participate in any sports? ◯Yes ◯No
If yes, what kind of exercise/sports? _____
_____
- Do you perform any repetitive movement in your work, sports or hobby? ◯ Yes ◯ No
If yes, describe _____
- Do you sit for long hours at a workstation, computer or driving? ◯ Yes ◯ No
If yes, describe _____
- Do you experience stress in your work, family or other aspect of your life? ◯Yes ◯No
If yes, describe _____
_____
- Are you experiencing tension, stiffness, discomfort or pain? ◯ Yes ◯ No
If yes, describe _____
_____
- Have you recently had an injury, surgery, or area of inflammation? ◯ Yes ◯ No
If yes, describe _____
_____
- Do you have sensitive skin? ◯ Yes ◯ No
- Do you have any allergies to oils, lotions or ointments? ◯ Yes ◯ No
- List any medications you currently are taking

_____

_____

- List any known allergies _____

Health History

Musculoskeletal

__Bone or joint disease
__Tendonitis/Bursitis
__Arthritis/Gout
__Jaw Pain (TMJ)
__Lupus
__Spinal Problems
__Migraines/Headache
__Osteoporosis

Circulatory

__Heart Condition
__Varicose Veins
__Blood Clots
__High/Low Blood Pressure
__Lymphedema
__Thrombosis/Embolism

Respiratory

__Breathing Difficulty/Asthma
__Emphysema
__Sinus Problems
__Allergies: Specify_____

Nervous System

__Shingles
__Numbness/Tingling
__Pinched Nerve
__Chronic Pain
__Paralysis
__Multiple Sclerosis
__Parkinson's Disease

Skin

__Allergies, specify_____
__Rashes
__Cosmetic Surgery
__Athlete's Foot
__Herpes/Cold Sores

Psychological

__Anxiety/Stress Syndrome

__Depression

Digestive

__Irritable Bowel Syndrome

__Bladder/Kidney Ailment

__Colitis

__Crohn's Disease

__Ulcers

Other

__Cancer/Tumor

__Diabetes

__Drug\Alcohol/Tobacco Use

__Contact Lens

__Dentures

__Hearing Aids

Any other Medical Conditions not listed_____

Please Explain any of the conditions that you marked_____