



MAGIC FINGERS CLINIC

ALL REGISTERED
MASSAGE THERAPISTS

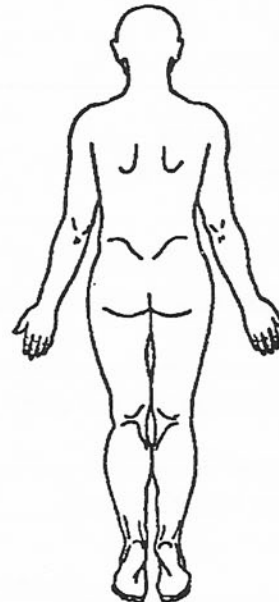
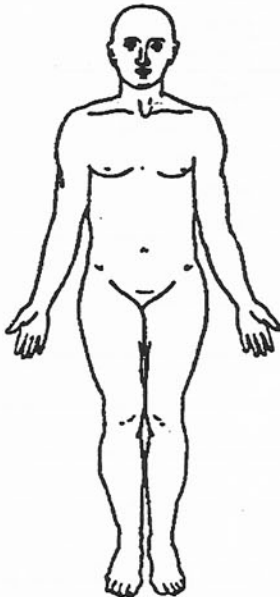
PERSONAL AND CONFIDENTIAL INFORMATION

Name _____ Date of birth _____
 Address _____ Phone (residence) _____
 _____ Phone (business) _____
 Postal Code _____ Occupation _____
 Name of Doctor _____ Name of Physio/chiro/ _____
 Alternate _____

HEALTH QUESTIONNAIRE

Do you feel that you are in good physical health? Yes / No
 Are you physically active? Yes / No
 Have you ever had a massage before? Yes / No

Please circle any area of pain/injury/discomfort.
 Also indicate any surgery, fractures, trauma and give appropriate dates



Is the pain (please circle)

more in the morning at night at work at rest travelling local
 dull achy sharp strong continuous
 tingling numbness loss of feeling

Pain is relieved by : _____

Pain is increased by: _____

How long have you had this pain? _____

Are you currently taking any medications? _____

Please list: _____

Please use a checkmark (✓) to indicate PRESENT CONDITIONS; use an (x) to indicate PAST CONDITIONS:

BONE/JT

- arthritis
- disk problems
- fracture
- back pain
- neck pain
- stiff joint
- swollen joint
- other _____

- pregnancy
- cancer
- allergies
- fatigue
- stress
- difficulty sleeping
- vision/speech/hearing
- fever
- other _____

MUSCLE

- strain/sprain
- cramps
- muscle weakness
- headaches
- stiffness
- other _____

- fibromyalgia
- chronic fatigue syndrome
- seizures/convulsions
- diabetes
- abdominal pain
- constipation/diarrhea
- HIV
- kidney problems
- other _____

CARDIOVASCULAR

- shortness of breath
- chest pain
- heart problem
- dizziness/fainting
- high blood pressure
- low blood pressure
- varicose veins
- clots
- other _____

LUNGS/SKIN

- rash
- eczema
- psoriasis
- smoker
- asthma
- emphysema
- cold/flu
- warts
- other _____

Please list any major illness/condition we should be aware of: _____

What is the reason for your visit? _____

How did you hear about us? _____

I _____ understand that the massage therapy given here is for the purpose of stress relaxation, relief from muscular tension of spasm. or for increased circulation.

It has been made clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I may have.

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Signature:

Date: