



Meiling Liu
Massage Therapist
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Health Questionnaire

Male Female Last Name: First Name:
Address:
Town: Postal Code:
Tel. Home: Work: Cell:
Date of Birth: Day Month Year Occupation:
E-mail:
Yes, you may send me appointment reminders and my statements via e-mail. No, do not contact me by e-mail.
How did you hear about us:

Date of first appointment: Day Month Year Insurance? Yes No
Company:

Reason for consultation:

Have you ever seen a doctor about this? Yes No
Have you ever seen a therapist? Yes No If yes, which one?
(Ex: physiotherapist, chiropractor, other)

What are your expectations?

Women only: Are you pregnant? Yes No Do you have a high risk pregnancy? Yes No
Expected date of delivery: / / (yyyy/mm/dd)
Are your menstruation regular irregular • Are you menopausal? Yes No
If so, what are your symptoms?

Do you suffer from digestive problems, diabetes or other diseases? Yes No If yes, precise.

Do you take medications? Yes No If so, which one?

Do you have allergies? Yes No If yes, please list

Do you have headaches? Yes No

Have you ever had:

Surgeries? Yes No If yes, please list:

An accident? Yes No

Other:

Are you presently suffering from cardiovascular problems? Yes No

Hypertension? Low Pressure? Angina? Migraine?

Heart problems? Yes No

Palpitations Infarcts Stroke If so, when? _____

Vasvcular problems? Yes No

Varicose veins Phlebitis If yes, where and when? _____

Do you wear orthotics? Yes No Contact lenses? Prostheses? Other? _____

How would you rate your diet?

- Excellent
- Good
- Fair
- To be monitored

What exercises do you do? How often?

The customer or client, by his signature certifies that the information and other information provided in this customer record are true and genuine. I also certify that I have advised, hereby, the therapist of any problem that could come in between my care

Client's signature: _____ Date: _____

In the diagrams below, circle the sore spots and indicate your stress points.

