Serenity Massage Centre

PATIENT INFORMATION/HEALTH QUESTIONNAIRE

First Name _____ M.I. _____ Last Name _____ Nick Name _____

Address _____ City _____ State _____ Zip Code _____

Gender: [ ] Male [ ] Female Primary Language _____ Date of Birth _____

Marital Status: [ ]Single [ ]Married [ ]Widowed [ ]Divorced [ ]Legally Separated Spouse Name:_____

Race:
[ ] Caucasian [ ] American Indian or Alaska Native [ ] African American or Black [ ] Asian [ ] Hawaiian or Pacific Islander [ ] Decline to Specify

Ethnicity: [ ] Not Hispanic or Latino [ ] Hispanic or Latino [ ] Decline to Specify

Contact preference for appointment reminders:

[ ] **Text Message Preferred** _____ [ ] Phone Call _____
CELL PHONE Cell / Home /Work Phone

[ ] Email: _____ [ ] Do Not Contact for Appointment Reminders

Emergency Contact Name _____ Phone Number _____

Do you prefer silence during your massage? [ ] Yes [ ] No

Who Referred You to Us? [ ] Physician [ ] Friend [ ] Internet [ ] Other/Referral Name: _____

Do you have any of the following conditions:

[ ] High Blood Pressure	[ ] Heart Problems	[ ] Pregnant ___wks	[ ] Circulatory Condition	[ ] Headaches/Dizziness	[ ] Foot Fungus
[ ] Contagious Disease	[ ] Varicose Veins	[ ] Nursing	[ ] Joint Pains	[ ] Poison Ivy	[ ] Athlete's Foot
[ ] Fibromyalgia	[ ] Arthritis	[ ] Cancer	[ ] Phlebitis	[ ] Spinal Problems	[ ] Asthma
[ ] Pacemaker	[ ] Diabetes	[ ] Epilepsy	[ ] Seizures	[ ] Blood Clots	

Have you had a massage before? [ ] Yes [ ] No Recent Surgeries:_____

List areas of tension, pain, or discomfort: _____

Do you have any special needs your therapist should be aware of? _____

List any prescription medications you are taking: _____

List any allergies: [ ] None _____

Contacts: [ ] Yes [ ] No Sensitivity to iodine, oil, or fragrances: [ ] Yes [ ] No Sensitivity to latex: [ ] Yes [ ] No

Patient ID#:_____