WRIGHT WELLNESS
www.wrightwellness.me
1398 W. Mayfield Rd., Suite 220
Arlington, TX 76015
office@wrightwellness.me
682.777.4325

Massage Therapy Questionnaire

Today's date: _____/_____/_____

Identification

Legal Name:_____ Age:_____Date of Birth:____/____/_____

Preferred Name:_____Sex (only required for insurance):_____

Gender Identity: _____Preferred Pronouns:_____

Race & Ethnicity:_____Race & Ethnicity Details: _____

Home street address:_____

City/State/Zip:_____

Phone (Primary):_____ Email: _____

Calls/texts/e-mails will be discreet, but please indicate any restrictions:_____

Occupation /Employment status:_____Military Experience:_____

Emergency Contact

If an emergency arises and we cannot reach you directly and we need to reach someone close to you, whom should we call? By listing someone below, you give permission for them to be contacted in the case of an emergency:

Name: _____

Phone: _____ Relationship: _____

Primary Medical Care (A signed release is required for treatment coordination)

Primary Care Provider_____Location/Phone_____

Legal History

Is your reason for coming to see us related to an accident or injury? ❑ Yes ❑ No If yes, please explain:

_____

Have you every had to file a complaint or been involved in a lawsuit with another health professional?

❑ Yes ❑ No If yes, please explain:

_____

For minors, has this minor been named in a custody agreement, court order, and/or divorce decree? ❑ Yes ❑ No If yes, please provide a copy of this document along with other standard paperwork and all applicable adults will be contacted in accordance with this agreement. Failure to provide this information initially will result in services being stopped until documentation is obtained.

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Medical History

Please check **all** MEDICAL conditions or you **have had** or **are having**:

❑ AIDS/HIV Positive
❑ Alcoholism
❑ Anxiety/PTSD
❑ Autoimmune Disorder
❑ Allergies
❑ Anorexia
❑ Appendicitis
❑ Arthritis
❑ Asthma
❑ Bleeding Disorder
❑ Blood clots
❑ Bone or joint disease
❑ Brain Injury
❑ Broken bones
❑ Bronchitis
❑ Bruise easily
❑ Bulimia
❑ Cancer
❑ Cataracts
❑ Chest Port
❑ Congestive Heart Failure
❑ Chicken Pox
❑ Chronic Pain
❑ Deep vein thrombosis
❑ Dementia
❑ Depression
❑ Diabetes
❑ Digestive conditions (i.e. Crohn's, IBS)
❑ Emphysema
❑ Epilepsy/Seizures
❑ Glaucoma
❑ Goiter
❑ Gout
❑ Heart condition
❑ Heart disease
❑ Hepatitis
❑ Hernia
❑ Herpes
❑ High/Low Blood Pressure
❑ High Cholesterol
❑ Jaw pain (TMJ)
❑ Kidney Disease
❑ Liver Disease
❑ Lupus
❑ Lymphedema
❑ Measles
❑ Meningitis
❑ Migraines/Headaches
❑ Mononucleosis
❑ Multiple Sclerosis
❑ Mumps
❑ Osteoporosis
❑ Pacemaker
❑ Parkinson's Disorder
❑ Pelvic Inflammatory
❑ Phlebitis or varicose veins
❑ Pneumonia
❑ Polio
❑ Prostate problems
❑ Rheumatic Fever
❑ Sciatica
❑ Scoliosis/spinal problems
❑ Sensitive skin
❑ Sexually Transmitted Disease
❑ Sinus problems
❑ Stroke
❑ Substance Abuse or Dependence
❑ Tendonitis/bursitis
❑ Thrombosis/embolism
❑ Thyroid Problems
❑ Tuberculosis
❑ Ulcers
❑ UTIs
❑ Other: _____
❑ Other: _____
❑ Other: _____

Are there any medical conditions indicated above that are still **present** and could potentially be impacted by a massage? ❑ No ❑ Yes If yes, please describe the present condition, and the year the condition began and/or was diagnosed by a healthcare professional: _____

_____

_____

_____

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For any **present** conditions listed above, what steps have you taken to treat your condition/symptoms?

_____

_____

Please check any **physical symptoms or experiences** you have had within the last month and/or have prompted you to seek services.

❑ Muscle stiffness/tension
❑ Muscle Pain
❑ Muscle Spasm
❑ Nerve pain
❑ Numbness or tingling
❑ Traveling pain
❑ Ticks or switches
❑ Accelerated heart rate
❑ Redness or inflammation
❑ Other: _____
❑ Other: _____
❑ Other: _____

Do you have a **history** of any prior surgeries or other significant medical procedures? ❑ No ❑ Yes

If yes, please indicate dates, reason and the outcome?_____

_____

_____

Have you had any injuries or surgeries in the last 6 months? ❑ No ❑ Yes If yes, please explain:_____

_____

_____

Do you have any family history of major medical health conditions? ❑ No ❑ Yes If yes, please describe what you are willing to: _____

_____

Do you ***currently*** take medications for medical and/or mental health conditions? ❑ No ❑ Yes If yes, please indicate what medications and dosage? _____

_____

_____

Massage Therapy History

Have you received professional massage services in the past? ❑ No ❑ Yes If yes, what type:

_____

_____

Overall experience, and any reason you did not continue? _____

_____

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_____

Have you been to a physical therapist or chiropractor for your symptoms? ❑ No ❑ Yes If yes, what was the outcome? _____

_____

_____

Massage Therapy Goals

Please tell us the reason you are seeking massage therapy services now and your specific health goals:

_____

_____

_____

_____

_____

Are there any current physical symptoms you would like the therapist to be particularly aware of? ❑ No ❑ Yes If yes, please describe the location of the areas of discomfort and when those symptoms began:

_____

_____

_____

What type of pressure do you prefer? ❑ Light ❑ Medium ❑ Firm Other: _____

_____

Please select any specific services or add-ons that you are interested in. Our therapist will discuss these further with you at your first session: ❑ Swedish Massage ❑ Aromatherapy ❑ Movement Cupping

❑ Deep Tissue/Trigger Point ❑ Muscle Manipulation tool ❑ Other: _____

❑ Consultation massage (thorough evaluation, introductory massage, and ongoing treatment plan)

Which areas, if any, would you like the therapist to avoid? ❑ NA ❑ Yes If yes, please explain: _____

_____

_____

Are you currently ❑ pregnant ❑ wearing contacts ❑ wearing dentures ❑ wearing hearing aides ❑ wearing hair extension/wig ❑ Not applicable ❑ Other: _____

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Do you have any allergies to oils, lotions or ointments? ❑ No ❑ Yes If yes, please explain: _____

_____

_____

Do you sit for long hours throughout the day, such as at a computer or driving? ❑ No ❑ Yes If yes, please explain: _____

_____

_____

Do you exercise regularly and/or participate in sports? ❑ No ❑ Yes If yes, please explain: _____

_____

_____

Do you perform any repetitive movements in your work, sport, or hobbies? ❑ No ❑ Yes If yes, please explain:_____

_____

Please feel free to share any other relevant information or anything you feel would benefit our work together: _____

_____

_____

_____