



PERSONAL DATA

Name: _____ Date: ___ / ___ / ___ Age: _____ DOB: _____
Address: _____ Home Phone: _____
City/State/Zip: _____ Cell Phone: _____
Occupation/Employer: _____ E-Mail: _____
Physician's Name: _____ Physician's Phone #: _____
Does your physician know you are participating in this exercise program? YES _____ NO _____
Name of Person To Notify in Case of Emergency: _____
Relationship to You: _____ Home #: _____ Work #: _____
What drugs or medications are you taking, if any: _____
Describe your current exercise program: _____

ACTIVITY HISTORY

1. Please rate your activity level on a scale of 1 to 5 (1 = Not At All Active, 5 = Very Active) for each age range up to your present age.

15-20 yrs: _____ 21-30 yrs: _____ 31-40 yrs: _____ 41-50 yrs: _____ 51-60 yrs: _____

2. Were you a high school and/or college athlete? If yes, please specify:

3. Do you have any special feelings (positive or negative) towards physical activity or an exercise program? If yes, please specify: _____

4. Rate yourself on a scale of 1 to 5 (5 being highest) for each of the following statements:

- a. My present athletic ability: _____
- b. My present cardiovascular ability: _____
- c. My present muscular ability: _____
- d. My present flexibility capacity: _____
- e. When I exercise, how much I like it to be competitive: _____

5. Do you start exercise programs and then find yourself able to stick to them? Yes ____ No ____

6. How much time are you willing to devote to an exercise program?
_____ minutes per day _____ days per week

7. Are you currently involved in regular cardiovascular exercise? Yes ____ No ____
If yes, please specify what type:
_____ minutes per day _____ days per week

Please rate the exertion level of your current program, if applicable, by checking one of the following boxes:

- Light Fairly Light Somewhat Hard Hard

8. Are you currently on a strength-training program? Yes ____ No ____
If yes, please specify:
_____ minutes per day _____ days per week

Please rate the exertion level of your current program, if applicable, by checking one of the following boxes:

- Light Fairly Light Somewhat Hard Hard

9. How long have you been exercising regularly? _____

10. What exercises, sports or recreational activities have you participated in the past six months?

11. Are you able to exercise on a workday? Yes ____ No ____

12. What days and hours are you available for an exercise program?

Please Specify: _____

- Difficulty with physical exercise
- Advice from a physician to avoid exercise
- Surgery within the last 12 months
- Pregnancy within the last 3 months
- Breathing or Lung problems
Muscle, Joint, or Back pain
- Diabetes or Thyroid condition
- Cigarette smoking habit
- Elevated Blood Cholesterol
- Increased Blood Pressure
- Hernia or similar condition
- Regular Alcohol consumption
- Neck problems or recurring Headaches

Please explain any answers below then fill out back of page:

SAFETY QUESTIONNAIRE

List all previous or current injuries, pains, aches, ailments for Joints, Nerves, Muscles, Bones or Tendons

Legs	Hips	
	Ankles	
	Hamstrings	
	Calves	
	Buttocks	
	Thighs	

	Knees	
	Feet	
Back	Upper	
	Middle	
	Lower	
	Spine	
	Core	
Shoulders	Right	
	Left	
Arms	Wrists	
	Elbow (R)	
	Elbow (L)	
Chest	Right	
	Left	
Abs		
Neck		

TIME MANAGEMENT

Please answer questions 1-5 in the following manner:

1 for poor 2 for fair 3 for average 4 for good 5 for excellent

1. Overall I'm able to manage my time _____
2. I devote adequate time to study information that will enable me to be successful _____
3. I do not put off what I'm supposed to do _____
4. I am able to make sure that I can exercise in a quality manner _____
5. I can mentally prepare for exercise efficiently _____
6. I am able to add and include appointments in my schedule without difficulty _____
7. I am able to say no to people and decline to do things when time doesn't permit _____
8. I don't take on more things or responsibilities than I can handle _____
9. I am able to plan out a weekly schedule for my life _____
10. I spend quality time with family and friends _____

Please answer questions 11-22 with a yes/no or as necessary:

11. Do you usually eat at the same times every day during the week _____
12. Do you get up at the same time every day during the week _____
13. Do you go to bed at the same time every day during the week _____
14. Do you set aside specific times for stretching during the week _____
15. Do you set aside specific times for cardiovascular exercise during the week _____
16. Do you set aside specific times for weight training during the week _____
17. How many hours of sleep do you average a night during the week _____
18. How many times during the week do you eat out _____
19. How many hours a week do you work _____ Do you work on the weekends _____
20. How many hours a day do you work _____ Do you consider yourself a workaholic _____
21. Are you usually late, early or right on time for appointments or responsibilities _____
22. Do you make time to prepare food for yourself _____

**Please list in order of importance from #'s 1 to 10. Only use a number one time:
1 being most important and 10 being least important.**

- | | |
|--------------------------------|--------------------------------------|
| _____ Work / Career / Business | _____ Family / Intimate Relationship |
| _____ Spirituality | _____ Entertainment / Going Out |
| _____ Hobby | _____ Television |
| _____ Exercise | _____ Recreation / Sport / Activity |
| _____ Computer Time | _____ Study / Reading |

NUTRITION QUESTIONNAIRE

1. If you are taking medication, do you feel it is helping you? _____
2. Are you taking vitamins and or nutritional supplements _____ If yes, please explain

3. Approximately how many regular-size glasses of water do you drink per day _____
4. Do you smoke _____ If yes, what of and how many per day _____
5. Do you drink alcohol _____ If yes, what of and how many a week _____

6. How many cups of coffee do you drink per day _____
7. List all beverages you drink regularly _____
8. Approximately what percentage of the food you eat is “convenience oriented” _____
9. How often do you eat “Fast Food” weekly _____
10. Do you use salt on your food _____
11. Do you try to keep fat calories from your diet _____
12. Do you use condiments such as catsup, BBQ sauce or A1 _____
13. Do you cut the extra fat from your meat _____
14. Do you use margarine or butter _____
15. Do you like oil type dressings on your salad _____
16. Do you eat cheese _____
17. Do you drink milk _____ If yes, how much per week _____
18. Do you like foods with a high sugar content like donuts, or pastries _____
19. Do you eat sugar coated cereal _____ If yes, which kind _____
20. Do you add sugar to your food _____
21. Do you add sugar to your coffee or tea _____ If yes, how much _____
22. How many cans or bottles of soft drinks do you consume weekly _____
23. When you eat bread is it white or wheat _____
24. Do you eat breakfast _____
25. Do you eat late at night _____
26. Do you often feel hungry no matter how much you eat _____
27. Do you usually feel better after eating _____
28. Do you usually feel worse after eating _____
29. Do you snack a lot between meals _____
30. List the snacks you prefer _____
31. Do you frequently skip meals _____
32. Do you have to watch what you eat to avoid gaining weight _____
33. Do you have to watch what you eat to avoid losing weight _____
34. Do you eat fruit daily _____
35. Do you eat vegetables daily _____
36. Do you eat meat daily _____
37. Are most of the vegetables you eat raw or cooked _____

38. Which foods if any irritate your stomach or bowels _____
39. What foods do you especially like _____
40. What foods do you especially dislike _____
41. Do you feel that your diet is lacking in some respect _____
42. Do you feel that your diet is excessive in some respect _____

MESSAGE HISTORY/TREATMENT

Have you ever received a professional massage or bodywork? _____ Yes _____ No

If yes, frequency _____ Date of last massage _____

What results do you want from your massage session?

Prioritize the areas of your body that you would prefer to be massaged.

Are there any areas of your body that you prefer not be massaged?

Are you currently seeing a medical practitioner? Please explain if yes. _____ Yes _____ No

Are you currently seeing a psychotherapist or are you attending regular support group meetings?

Please explain if yes. _____ Yes _____ No

List stress reduction and exercise activities. Include frequency.

List current medications, including medications, including aspirin, ibuprofen, etc.

HEALTH HISTORY (Please check all that apply)

Surgeries/Injuries: _____

Accidents: _____

MUSCULO-SKELETAL

- _____ bone or joint disease _____
- _____ tendonitis _____
- _____ Bursitis _____
- _____ broken/fractured bones _____
- _____ arthritis _____
- _____ sprain/strains _____
- _____ low back, hip, leg pain _____
- _____ neck , shoulder, arm pain _____
- _____ headaches/head injuries _____
- _____ spasms/cramps _____
- _____ jaw pain /TMJ _____
- _____ lupus _____
- _____ other _____

CIRCULATORY

- _____ heart condition _____
- _____ varicose veins _____
- _____ blood clots _____
- _____ high blood pressure _____
- _____ low blood pressure _____
- _____ lymphedema _____
- _____ breathing difficulty _____
- _____ sinus problems _____
- _____ allergies _____
- _____ other _____

INFECTIOUS DISEASE

_____ disease name(s): _____

SKIN

- _____ allergies _____
- _____ rashes _____
- _____ athletes foot _____
- _____ warts _____
- _____ other _____

DIGESTIVE

- _____ constipation _____
- _____ gas/bloating _____
- _____ diverticulitis _____
- _____ irritable bowel syndrome _____
- _____ other _____

NERVOUS SYSTEM

- _____ herpes/shingles _____
- _____ numbness/tingling _____
- _____ chronic pain _____
- _____ fatigue _____
- _____ sleep disorders _____
- _____ other _____

REPRODUCTIVE

- _____ pregnant? Stage _____
- _____ PMS _____
- _____ other _____

OTHER

- _____ cancer/tumors _____
- _____ diabetes _____
- _____ eating disorders _____
- _____ depression _____
- _____ drug/alcohol addiction _____

_____ nicotine/caffeine addiction _____

It is my choice to receive massage therapy/body work/corrective exercise. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm, pain or for increasing circulation of energy flow. I agree to communicate with my practitioner any time I feel like my well-being is being compromised.

I understand that massage practitioners and fitness professionals do not diagnose illness, disease or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals or perform spinal thrust manipulations. I acknowledge that massage and corrective exercise is not a substitute for medical examination or diagnosis, and that is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner or fitness professional of any changes in my health status.

SIGNATURE: _____ DATE: _____