YMCA OF THE NORTH

Massage/Bodywork First Session Questionnaire

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

First _____ M.I. _____ Last _____

Birthdate ____/____/____ ☐ I am 18 years of age or older Date _____

PURPOSE

What are the main health concerns for which you are seeking care?

What are your particular goals and expectations of care? Please explain:

STRESS

Rate your level of chronic stress (10 = high) Low 1 2 3 4 5 6 7 8 9 10 High

In what areas of your life do you have significant stress? (work, family, or another area)

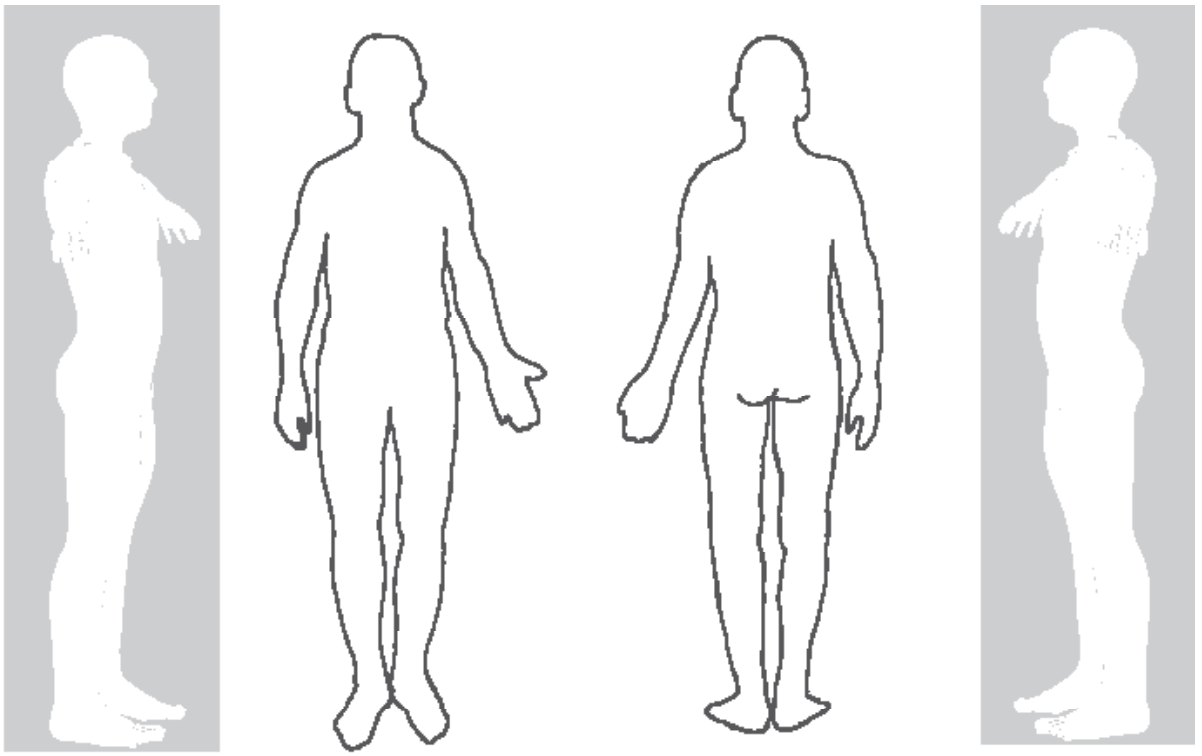
If applicable, how has chronic stress affected your health?

☐ Anxiety ☐ Muscle tension ☐ Insomnia ☐ Irritability ☐ Other _____

Please indicate where you have pain, discomfort or other symptoms below:

KEY

Numbness	═══
Pins & Needles	00000
Burning	XXXXX
Stabbing	/////
Aching	++++
Other	*****



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Please indicate if you have had any joint issues or surgeries that may limit or affect your ability to receive bodywork.

- ☐ Ankle left
- ☐ Ankle right
- ☐ Elbow left
- ☐ Elbow right
- ☐ Hip left
- ☐ Hip right
- ☐ Knee left
- ☐ Knee right
- ☐ Low back
- ☐ Neck
- ☐ Shoulder left
- ☐ Shoulder right
- ☐ Wrist/hand left
- ☐ Wrist/hand right
- ☐ Other _____

HEALTH HISTORY

Please check any of the following condition(s) that CURRENTLY applies to you:

- ☐ Fever
- ☐ Eczema or psoriasis
- ☐ Cardiovascular Disease
- ☐ Fibromyalgia
- ☐ Anxiety
- ☐ Osteoporosis
- ☐ High or low blood pressure
- ☐ Varicose veins
- ☐ Other _____
- ☐ Infectious/communicable skin disease
- ☐ Cancer
- ☐ Chronic Lung Disease
- ☐ Low back pain
- ☐ Recent trauma (accident, fall)
- ☐ Arthritis
- ☐ Headache/migraine
- ☐ Insomnia/difficulty sleeping
- ☐ Common cold symptoms
- ☐ Lymphoma
- ☐ Liver Disease
- ☐ Depression
- ☐ Dizziness/vertigo
- ☐ Stroke
- ☐ Constipation
- ☐ Pacemaker
- ☐ Allergies/intolerances/sensitivities (please list)
- ☐ Open sore/wound/ulceration
- ☐ Diabetes
- ☐ Digestion (IBS, Crohn's, etc)
- ☐ Mental health
- ☐ Hypertension
- ☐ Seizure
- ☐ Cold hands and feet
- ☐ Heart palpitations

Please explain any condition(s) that you have marked:

Have you experienced any of these conditions in the PAST, but not currently? ☐ Yes ☐ No If yes, please explain.

Have you experienced any significant illnesses, traumas, accidents, surgeries, or hospitalizations? ☐ Yes ☐ No If yes, please describe WITH dates.

Are you currently taking any prescription medications? ☐ Yes ☐ No Medicinal herbs? ☐ Yes ☐ No Supplements? ☐ Yes ☐ No
If yes, please list (name and dosage).

Are you pregnant? ☐ Yes ☐ No

Are you currently trying to become pregnant? ☐ Yes ☐ No

IS THERE ANY OTHER INFORMATION YOU WOULD LIKE TO SHARE WITH YOUR PROVIDER?

Client Name

Parent or Guardian (if applicable)

Signature

Date