QUINTE ORTHOPAEDICS
& REHABILITATION SPECIALISTS

Massage General Health Questionnaire:

Name:_____ Date:_____

1. Do you have any heart problems? Yes No
2. Do you have any thyroid problems? Yes No
3. Do you have HIGH or LOW blood pressure? Yes No
4. Are you currently taking any medications? If yes, please list

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5. Have you been diagnosed with arthritis? Yes No
6. Do you have diabetes? Yes No
7. Do you have or ever had cancer? Yes No
8. Have you ever broken a bone? Yes No
9. Do you have any metal fixations, plates, screws, etc.? Yes No
10. Do you have any skin infections? _____ Yes No
11. Do you have any abdominal problems, ie. hernia, ulcer? Yes No
12. Have you had any previous surgeries (please list) Yes No

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13. If female, are you or could you be pregnant? Yes No
14. Have you been involved in a previous car accident? Yes No

If yes, date: _____

15. Do you have any allergies, irritations, infections, etc? Yes No
16. Do you have asthma or any respiratory problems? Yes No
17. Do you have any other health problems not listed above? Yes No
18. Are there any other reasons that you should not do physical activities? Yes No
19. Emergency contact person:_____ Phone Number:_____

Client's Signature:_____