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BLUE ZONE HEALTH

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MISSION: TO RAISE THE VIBRATION OF EVERYONE WHO WALKS THROUGH OUR DOOR.
VISION: TO REVOLUTIOIZE HEALTHCARE IN OUR COMMUNITY.

Massage Therapy Questionnaire

Today's Date:_____

Name:_____ Date of Birth:_____ Age:_____

Any change in your personal information (i.e., address, etc.) from what we have on file?

☐ Yes, there is a change *(please provide this information)* ☐No Change

Have you ever had a professional massage? ☐ Yes ☐ No

What is your preferred pressure? ☐ Light ☐ Medium ☐ Heavy ☐ Unsure

Do you have any allergies? _____

Do you have any skin sensitivities? _____

Do any of the following apply to you?

___Arthritis	___Headaches	___Sciatica	___Torn Ligament
___Bruise easily	___Heart Disease	___Scoliosis	___Varicose veins
___Cancer	___Hypertension	___Tendinitis	___Wear Contacts
___Diabetes	___Osteoporosis	___Torn muscle _____	
___Digestive issues	___Pregnant	___Other _____	

___Skin condition (including warts, open lesions/broken skin, etc)_____

Please explain any of the above checked conditions further _____

_____

_____

What is your primary reason for receiving a massage treatment today? _____

_____

On the flip side, please indicate your areas of pain and discomfort on the diagrams. ⇨

Signature_____

Date_____

Body Scan Evaluation Form