

# Limelight Therapy

Natural Health Clinic

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## Massage Questionnaire

*All information provided in this questionnaire is treated as strictly confidential.*

Full Name \_\_\_\_\_

Address \_\_\_\_\_

Post Code \_\_\_\_\_ E- mail \_\_\_\_\_

Tel: Home \_\_\_\_\_ Mob. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Occupation \_\_\_\_\_

Name and address of your GP \_\_\_\_\_

Do I have your consent to contact your GP if required? \_\_\_\_\_

Health complaints \_\_\_\_\_

### Health History

Have you ever had any surgery or hospitalisation?

More than 10 years ago:

5 to 10 years ago:

Less than 5 years ago:

Have you ever been involved in an injury or an accident?

More than 10 years ago:

5 to 10 years ago:

Less than 5 years ago:

What kind of care did you receive?

Do you consider that you have recovered from these events?

Do you have any chronic, ongoing conditions that you deal with on a regular basis?

\_\_\_\_\_

Are you taking any medication? \_\_\_\_\_

Are you currently seeing a doctor for any reason?

\_\_\_\_\_

Are you currently receiving any other treatments? \_\_\_\_\_

Please tick any conditions you currently suffer of have suffered:  
(C - current, P - Past)

<b>Skin</b>				
Boils		Warts		Dermatitis
Fungal infection		Eczema		Skin cancer
Herpes simplex		Psoriasis		

<b>Muscle and Joints</b>				
Fibromyalgia		TMJ dysfunction		Carpal tunnel syndrome
Rheumatoid arthritis		Strains, sprains or tendinitis		Thoracic outlet syndrome
Osteoarthritis				

<b>Nervous System</b>				
Anxiety		Irritability		Seizure disorders
Depression		Lack of concentration		Panic attacks
Fatigue		Mood swings		Schizophrenia
Sleep disorders		Nervous breakdown		Poor memory
Lethargy		Nervous exhaustion		Multiple sclerosis
Postpolio syndrome		Headaches		Stroke
Reduced sensation		Chemical dependency		

<b>Circulatory system</b>				
Anaemia		High blood pressure		Varicose veins
Thrombophlebitis		Heart disease		Clotting disorders
Deep vein thrombosis				

<b>Lymph/Immune system</b>				
Oedema		HIV/AIDS		Lupus
Leukaemia/Lymphoma		Chronic Fatigue Syndrome		Other autoimmune disorders
Cancer (any type)		Water retention		Ear infection

<b>Respiratory system</b>				
Asthma		Bronchitis		Emphysema
Sinusitis		Tuberculosis		

<b>Digestive system</b>				
Reflux		Ulcerative colitis		Gall stones
Ulcers		Irritable bowel syndrome		Cirrhosis
Crohn's disease		Hepatitis		

<b>Endocrine system</b>				
Diabetes		Hypothyroidism		Hyperthyroidism

<b>Urinary system</b>				
Renal failure		Kidney infection/stones		Painful urination

<b>Reproductive system</b>				
Amenorrhoea (absence of periods)		Dysmenorrhoea (painful periods)		Heavy menstrual flow
Breast cancer		Endometriosis		Ovarian cysts
Prostate cancer				

Are you pregnant?      Yes/No

If yes, how many weeks \_\_\_\_\_

**Treatment Goals:**

Why are you here? What do you want to accomplish?

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**Additional information**

Please provide any other information, which you think, may be relevant:

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**How did you find us?** \_\_\_\_\_

The information provided above is true, accurate and given to the best of my knowledge. I hereby give my consent for a massage treatment on myself.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_