SCANDINAVE SPA
BLUE MOUNTAIN

HEALTH QUESTIONNAIRE

DATE _____

FIRST NAME _____ LAST NAME _____

ADDRESS _____ PHONE NUMBER _____

DATE OF BIRTH ___ ___ ____ GENDER _____
DD MM YEAR

MASSAGE HISTORY

Is this your first massage experience? ☐ Y ☐ N If not, how often do you have massages? _____

MEDICAL HISTORY

Have you ever experienced or are you experiencing any of the following health problems? (This information shall remain confidential).

	Y	N	Details / Medication
Allergies (iodine, seafood, almonds or other nuts, massage oils, food...)	☐	☐	_____
Hemophilia	☐	☐	_____
Cardiac problems (pacemaker...)	☐	☐	_____
High blood pressure, low blood pressure	☐	☐	_____
Contagious disease	☐	☐	_____
Neurological disorders (headaches, migraine, epilepsy, CVA, stroke...)	☐	☐	_____
Skin problems (eczema, psoriasis, warts, athlete's foot)	☐	☐	_____
Cancer	☐	☐	_____
Muscle (joint pain, inflammation...)	☐	☐	_____
Fracture (injury, accident...)	☐	☐	_____
Soft tissue injury (sprain, strain, dislocation, whiplash...)	☐	☐	_____
Are you pregnant?	☐	☐	If yes, how many weeks? _____

Other pertinent information _____

I certify that the above information is true and complete. **Signature:** _____

FOR OFFICE USE ONLY:

Date: _____ Time: _____ am / pm Duration: _____ min / hr Massage Started at: _____ Fee: $ _____

☐ General Relaxation Technician Name: _____

AREAS TO BE TREATED: ☐ Head ☐ Face ☐ Neck ☐ Clavicle ☐ Scalp ☐ Arm L / R ☐ Hand L / R

☐ Leg L / R ☐ Foot L / R ☐ Back ☐ Hip ☐ Shoulder ☐ Other

AMOUNT OF PRESSURE USED: ☐ Very Light ☐ Light ☐ Medium

Technician Notes: _____