The Retreat
massage & spa
319.261.1364
www.retreatcr.com
1500 Center Street NE, Suite 102 ◆ Cedar Rapids, IA 52402

Health History Questionnaire

Name:_____ Home Phone: _____

Address:_____ Work/Cell Phone:_____

City, State Zip:_____ Birthdate:_____

E-Mail:_____ Physician: _____

Occupation:_____ Chiropractor: _____

Employer:_____ Referred By: _____

Emergency Contact and Phone Number:_____

If I need to contact you regarding your appointment, is it appropriate to call the above numbers?

Home Phone: Yes___ No___ Work/Cell Phone: Yes___ No___

Surgeries and Approximate Dates:_____

_____

Injuries in the last two years: _____

_____

Major illnesses or hospitalizations in the last two years:_____

_____

Irregular Pulse: Yes___ No___ Blood Pressure: High___ Low___ Normal___

Chronic illness(es) or discomfort(s)?_____

Medications currently taken (including over the counter and herbals):_____

_____

Please list any skin conditions or disorders: (Rash, Shingles, Varicose Veins, Psoriasis, Skin Allergies, etc.)

_____

If pregnant, please indicate trimester: 1st ____ 2nd ____ 3rd ____ Approximate Due date:_____

Obstetrician: _____

What do you do in your free time? (Hobbies, Activities, Sports, etc.)_____

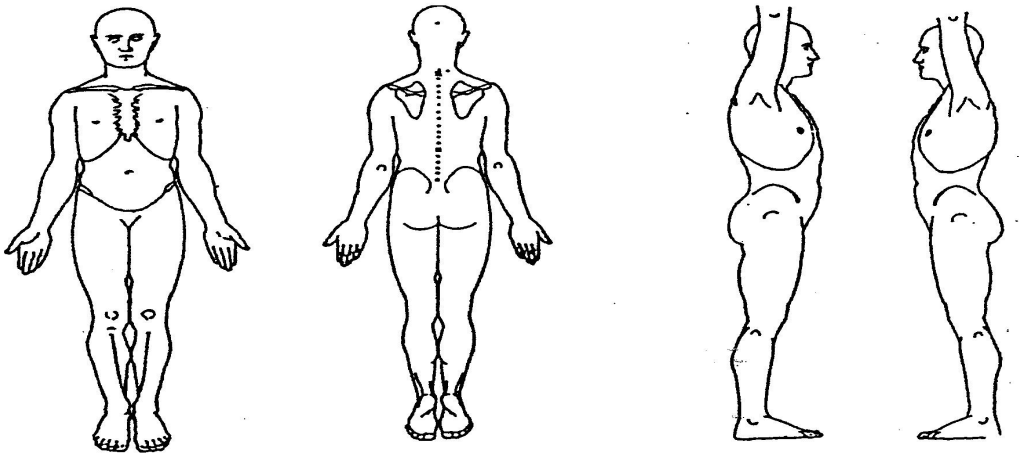
_____

Have you ever received a professional massage before? Yes___ No___

If yes, was there anything you liked or disliked? _____

Please list your reason for this visit:_____

_____



Please mark any areas of pain, tension or discomfort and give a brief description of what you are experiencing:

_____

_____

Please check the following conditions that apply to you, past & present. Please add your comments to clarify:

- ❑ Headaches/Migraines
- ❑ Joint Stiffness/Swelling
- ❑ Back or Neck Stiffness/Pain
- ❑ Jaw/TMJ Disorder
- ❑ Spasms/Cramps
- ❑ Broken/Fractured Bones
- ❑ Strains/Sprains
- ❑ Tendonitis
- ❑ Bursitis
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Bone or Joint Disease
- ❑ Dizziness/Lightheadedness
- ❑ Shortness of Breath
- ❑ Fainting
- ❑ Cold Hands or Feet
- ❑ Cold Sweats
- ❑ Swollen Ankles
- ❑ Pressure Sores
- ❑ Varicose Veins
- ❑ Blood Clots

- ❑ Stroke
- ❑ Heart Condition
- ❑ Allergies
- ❑ Sinus Problems
- ❑ Asthma
- ❑ Lymphedema
- ❑ Lymph Nodes Removed
- ❑ Rashes
- ❑ Athletes Foot
- ❑ Warts
- ❑ Moles
- ❑ Acne
- ❑ Cosmetic Surgery
- ❑ Nervous Stomach
- ❑ Heartburn/Reflux
- ❑ Constipation
- ❑ Intestinal Gas/Bloating
- ❑ Colitis
- ❑ Other Bowel Conditions
- ❑ Tension/Stress
- ❑ Depression
- ❑ Nervousness/Anxiety

- ❑ Aneurysm (Explain)
- ❑ Numbness/Tingling/Twitch
- ❑ Chronic Pain
- ❑ Sleep Disorders
- ❑ Paralysis
- ❑ Herpes/Shingles
- ❑ Cerebral Palsy
- ❑ Epilepsy/Seizure Disorder
- ❑ Multiple Sclerosis
- ❑ Muscular Dystrophy
- ❑ Parkinson's Disease
- ❑ Spinal Cord Injury
- ❑ Reproductive System
- ❑ Bladder Problems
- ❑ Fatigue
- ❑ Drug/Alcohol/Caffeine Use
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Post-Polio Syndrome
- ❑ Cancer
- ❑ HIV
- ❑ Infectious Disease (Explain)

Is there any other information I need to know before beginning your massage or spa service?_____

_____

I understand that massage and spa services given at The Retreat are for the purposes of muscular tension relief, relief of muscle spasm, reduction of stress, or to increase circulation and flow of energy, while benefiting the well being of my mind and body. I understand the massage therapist, esthetician, reflexologist or nail tech does not diagnose illness, disease or other physical or mental disorders. The massage therapist, esthecician, reflexologist or nail tech does not perform joint or spinal manipulations nor does she/he prescribe pharmaceuticals or medical treatments. I understand massage therapy and spa services are not a replacement for examinations and/or diagnosis by a medical professional, and it is recommended that I see a physician for any physical ailment I may have. A massage therapist, esthecician, reflexologist or nail tech must be aware of existing physical conditions, and as such I have stated all my known medical conditions and assume all responsibility and liability for information I do not disclose to the spa professional for this or future spa services.

Cancellation Policy: If cancellation or rescheduling is necessary, please notify your therapist or The Retreat 24-hours in advance. Without notifcation, clients are responsible for payment of missed appointments.

Signed _____ Date _____