Community College of Rhode Island

THERAPEUTIC MASSAGE STUDENT CLINIC SCREENING QUESTIONNAIRE

Name: _____ Age: _____

Address: _____

Phone: _____

Email Address: _____

Are you experiencing pains at this time? ☐ **Yes** ☐ **No**

Location of pains _____

Are you on any medication? ☐ **Yes** ☐ **No**

What for? _____

Have you had any surgery? ☐ **Yes** ☐ **No**

What for? _____

Have you had any recent Fractures? ☐ **Yes** ☐ **No**

Where?_____

How often do you exercise?

☐ **Daily** ☐ **Weekly** ☐ **Monthly** ☐ **Rarely** ☐ **Never**

What type of exercise? _____

Are you now or have you ever had problems with your:

Balance	☐ **Yes**	☐ **No**
Fainting	☐ **Yes**	☐ **No**
Bones/Joints/Muscles	☐ **Yes**	☐ **No**

Please check any illness you currently have or have had: (<u>If treated less than 6 weeks ago, please bring a Doctor's note</u>).

☐ **Heart attack (if so, how recent)**

☐ **Nervous Disorder**

☐ **High Blood Pressure**

☐ **Diabetes**

☐ **Osteoporosis**

☐ **Epilepsy**

☐ **Asthma (treated?)**

☐ **Vascular Disease (i.e., phlebitis)**

☐ **Cancer**

☐ **Tumor**

☐ **Arthritis**

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Please check all appointment times that you are available for:

☐ 9 a.m. ☐ 10:30 a.m. ☐ 12:30 p.m. ☐ 2 p.m.