



Health Questionnaire

Confidential when completed / GAB-SM 043 (révision 0, 11 nov. 2014)

Date of consultation <input type="text"/>	Name : _____
Motive of consultation <input type="text"/>	Occupation : _____
Massothérapeute agréé <input type="text"/>	Date de naissance : _____
	Phone number : _____
	E-mail : _____

Area of pain	Back (dorsal region) <input type="radio"/>	Back (lumbar region) <input type="radio"/>	neck <input type="radio"/>
	Superior member (low) <input type="radio"/>	inferior member <input type="radio"/> (front leg)	Inferior member <input type="radio"/> (back leg)

General considerations	Your sleep is: restorative <input type="radio"/> insufficient <input type="radio"/> frequent waking <input type="radio"/>
	Have you ever had: fractures <input type="radio"/> accident <input type="radio"/> surgery <input type="radio"/>
	Do you have allergies? yes <input type="radio"/> no <input type="radio"/>
	Are you suffering from skin problems? warts <input type="radio"/> eczema <input type="radio"/> psoriasis <input type="radio"/>
	Are you pregnant? yes <input type="radio"/> no <input type="radio"/> How many weeks ? : _____
	Have you suffered or are you suffering from cancer? Yes <input type="radio"/> no <input type="radio"/>

Systems	Joints problems: arthritis, osteoarthritis, tendinitis, etc.: yes <input type="radio"/> no <input type="radio"/>
	Circulation: hypertension, low blood pressure, migraine, cardiac insufficiency, etc. : yes <input type="radio"/> no <input type="radio"/>
	Digestive problems: constipation, diarrhea, ulcer, gastric reflux, etc.: yes <input type="radio"/> no <input type="radio"/>
	Hormonal problems: yes <input type="radio"/> no <input type="radio"/> Diabetes: yes <input type="radio"/> no <input type="radio"/>
	Nerve problems: Headache, stress, anxiety, etc.: yes <input type="radio"/> no <input type="radio"/>
	Respiratory problems: asthma, caught, emphysema, etc.: yes <input type="radio"/> no <input type="radio"/>

Have you consulted any professionals? yes no Which one : _____

Contraindications and/or treatment currently received: _____

Having acknowledged the health questionnaire, I certify that all of the information given to the certified massage therapist with the Fédération québécoise des massothérapeutes (FQM) is true and complete. I hereby authorize the certified massage therapist to share this information with the FQM representative duly authorized to conduct a professional inspection related to the performance of the certified massage therapist's professional's activities, as this information is necessary to the exercise of the FQM's responsibilities.

Client's signature: _____

Date	Brief summary	Therapeutic follow-up	Initials