Fédération québécoise des massothérapeutes agréés
DEPUIS 1979

Health Questionnaire
Masage Therapy

Confidential when completed

GAB-SM 044 (revision 5, Sept. 2023)

Date of consultation

Personal information

Name / surname :

Address :

Telephone : home | work | cell

Date of birth :

Occupation:

Describe a brief summary of the job (workstation)including physical requirements and emotional stress.

E-mail:

General

Do you have activities / leisure? yes❑ no ❑

Do you practice sports? yes❑ no❑

Have you already received amassage? yes❑ no ❑ date approximative :

Whatkind of massage? Swedish❑ Californian ❑ Shiatsu ❑ Trager[md]❑ Kinesitherapy❑ Hot stone ❑ Other❑

What do you prefer during the massage?

Motives for consultation

What motive brings you to massotherapy?

What do youfeel? Thightness❑ pain❑ Tingling or numbness❑ For how long?

Do you have any wounds or inflammation? yes❑ no ❑

Have you consulted a professional on this matter?yes❑ no ❑ If yes, what type of treatment have you received?

Are you receiving / have you received treatment? Yes ❑ no ❑

Pregnancy and menstrual cycle

Are you pregnant? yes ❑no❑ Due date : Pregnancy at risk❑ nausea❑

Menstrual cycle? regular❑ painful❑ PMS❑

menopause❑ Hot flashes❑ migraines❑

Pain assessment

Where do you have pain? neck (cervical region) ❑ back (dorsal region) ❑ back (lumbarregion) ❑
arms❑ legs (front) ❑ legs (back) ❑

How would you characterize your pain localized❑ withstiffness❑ radiating❑ _____

Is the pain…? stabbing❑ ardent❑ iches❑ cramps❑

Is itaccompanied of? headache❑ buzzing in youears❑ dizziness❑ vertigo❑

Doesitcomes on…? constant❑ periodic❑ occasional❑ _____

suddenly❑ progressively❑ during the day❑ onwaking❑ at night ❑

Whatfactorsexacerbate? coughing❑ defecating❑ standingupright❑ sitting❑lying down ❑

- sleep posture ❑ _____
- position / actions at work❑ _____
- activities of daily living ❑ _____
- sport : movementcausing pain❑ _____

Whatreleavedyour pain? _____

Do you currently suffer from…

Joint problemstendinitis❑ bursitis❑other : _____

Have you suffered / Are you suffering from cancer?yes❑ no ❑ _____

Skinproblem? itching❑ eczema❑ psoriasis❑ location : _____
lupus❑ wart❑ athlete's foot❑ location : _____

Cardio-vascularproblem? hypertension❑ lowblood pressure❑ angina❑ arrhythmia❑
palpitations❑ vascular migraine❑ Heartattack❑ stroke❑when?_____
varicoseveins❑ phlebitis❑ when / where? _____

Digestive problem? ulcer❑ gastric reflux❑ constipation❑ diarrhea❑
ulcerativecolities❑ liverproblem❑ other : _____

Endocrine system diabetes❑ hypoglyccemia❑ If yes, what time was your last meal? _____
What time was your last injection?_____

Allergies? food❑ respiratory❑ skin❑ other❑ _____

Sleepquality? restorative❑ insufficient❑ frequentwaking❑ difficultyfallingasleep❑

Do you watch your food habits? yes❑ no ❑ frequently❑ occasionaly❑ rarely❑

Have youundergoneany… ? surgery❑ fracture❑ accident❑ other❑

spécified _____

Do you take any medication? yes❑ no ❑ _____ _____

Sincewhen? _____ Anysideeffect : _____

Where you already handled for a medical condition? _____

In everyday life, how you do live your stress? _____

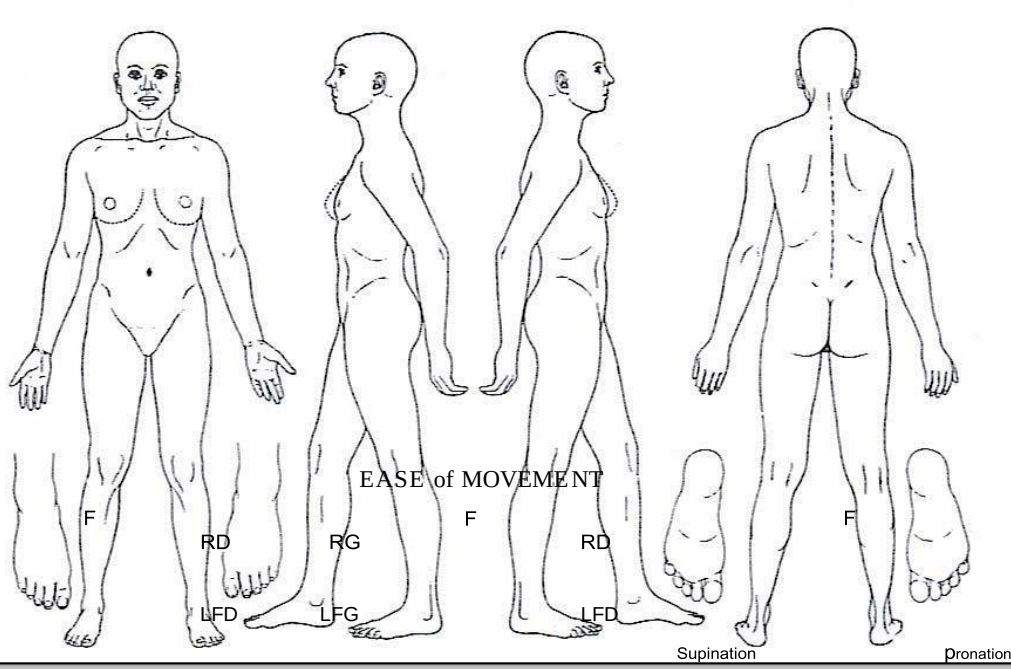
Notestoberegisteredforthedevelopmentofthefile

Onascalefrom0to10,estimateyourintensityfor:FATIGUE–EMOTION-PAIN

Fatigueandemotions	*PERCEPTIONSCALE*	*Pain*
Unbearable	**10**	Unbearable
Verypainful	**8-9**	Verypainful
Intense	6-7	Intense
Uncomfortable, moderate	4-5	Uncomfortable, moderate
Mild	2-3	Mild
Nofatigue, calm	0-1	No pain

Register the date andthe intensity

	date	intensity	date	intensity	date	intensity	date	intensity	date	intensity	date	intensity
Pain												
Fatigue												
Emotionalimpact												



LEGEND

Movementsrestriction

mild

considerablequasi-immobilitypainonmovement

Musclecontractions

lightcontracturepronoun

cedcontracture

extremecontracture

Pain

localofdiffusepain

shootingpai

TriggerPoint

myofascialezone

E	E	E
Structure:_____	Structure:_____	Structure:_____
_____Dates:D__D	_____Dates:D__D	_____Dates:D____D
_____D_____	_____D_____	_____D_____

F : Flexion E :Extension LF : Lateralflexion L : Left R: Right D :Colourcode &dates

Breathing:

Posture:

Tissuecondition or energetic condition (observation / palpation):

Otherobservations

TherapeuticFollow-up

Date: *Stateinitsarrival:* *serein*D *fatigue*D *exhausted*D *nervous* D *stress*D *sad*D

Painwhichshowsitself: _____*neck(cervicalregion)* D _____*back (dorsalregion)*D _____*back(lumbarregion)*D

_____*arms*D _____*legs (front)* D _____*legs(back)*D

Pillowforthecomfort: *neck*D *abdomen*D *shoulders*D *knees*D *ankles*D

Additionalinformation:

Therapeuticfollow-up:
(specificmaneuversandareascovered)

Recommendations:

Commentsreceived:

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Recommendations:

Commentsreceived:

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.

If uncomfortable, I am aware the massage session can be terminated at anytime–or that I can require clarifications from the massage therapist–regardless of the area of the body being massaged.

Signature du client : Date :