Fédération québécoise des massothérapeutes agréés
DEPUIS 1979

Health Questionnaire

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

Date of consultation

Motive of consultation

Massothérapeute agréé

Name : _____

Occupation : _____

Date de naissance : _____

Phone number : _____

E-mail : _____

Area of pain	Back (dorsal region) O Back (lumbar region) O neck O Superior member (low) O inferior member O (front leg) Inferior member O (back leg)
General considerations	Your sleep is: restorative O insufficient O frequent wakening O Have you ever had: fractures O accident O surgery O Do you have allergies? yes O no O Are you suffering from skin problems? warts O eczema O psoriasis O Are you pregnant? yes O no O How many weeks ? : _____ Have you suffered or are you suffering from cancer? Yes O no O
Systems	Joints problems: arthritis, osteoarthritis, tendinitis, etc.: yes O no O Circulation: hypertension, low blood pressure, migraine, cardiac insufficiency, etc. : yes O no O Digestive problems: constipation, diarrhea, ulcer, gastric reflux, etc.: yes O no O Hormonal problems: yes O no O Diabetes: yes O no O Nerve problems: Headache, stress, anxiety, etc.: yes O no O Respiratory problems: asthma, caught, emphysema, etc.: yes O no O

Have you consulted any professionals? yes O no O 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: _____

Therapeutic follow-up

Date	Brief summary	Initials