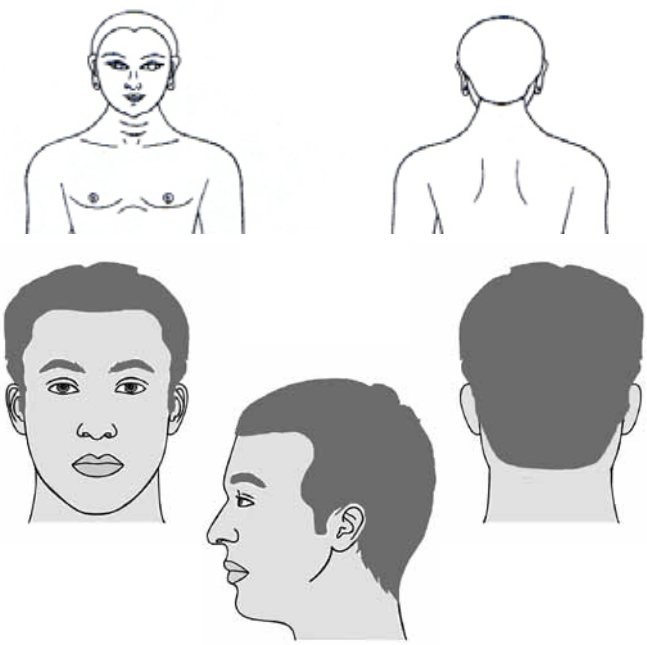
Head Massage Health Questionnaire

Lotus Palm

Name:
Phone:
Email:

Please circles your areas of tension on the drawing



• Do you have any movement restriction to be respected?
__ Yes __ No

If you checked yes above please describe:

_____

_____

_____

• Are you currently under the care of a physician?
__ Yes __ No

• Are you taking any medication/s? __ Yes __ No
Specify: _____

Please indicate below if you have any health conditions of which your practitioner should be aware:

• Severe migraines or dizziness __ Yes __ No

• Epilepsy __ Yes __ No

• Thrombosis or embolism __ Yes __ No

• Arthritis affecting the neck __ Yes __ No

• Fibromyalgia __ Yes __ No

• Cancer __ Yes __ No

• Spondylitis __ Yes __ No

• Inflammation or recent injuries to the head __ Yes __ No

• Open cuts, wounds or burns __ Yes __ No

• Allergic to nut oils/essential oils __ Yes __ No
Specify: _____

• How would you describe your skin?
__ Dry __ Oily __ Combination
Specify: _____

• Severe scalp conditions __ Yes __ No
Specify: _____

• How would you describe your hair/scalp?
__ Dry __ Oily __ Combination
Specify: _____

Date: / /	Signature:

DISCLAIMER: *The purpose of massage is for relaxation and not meant to diagnose or treat any illness, disease or any other physical or mental disorder, injury or condition. If you have a specific medical condition or symptom, receiving or performing massage may be contraindicated or require modification. A referral from your primary care provider may be requested prior to receiving and/or performing massage. Lotus Palm will not be held liable for any injury or similar condition that arises from the application of massage.*