

Institute of Natural Therapies Student Health Questionnaire

P.O. Box 222
Hancock, MI 49930

This will be used as a guideline and will remain confidential except if the class needs to know specific contraindications for massage therapy.

Name _____ Today's Date _____

Weight _____ Height _____ Birth date _____

Do you have, or have you been informed of any of the following conditions, or health problems?
Please write the answer "yes" or "no"

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|----------------------------------|---------------------------------|--------------------------------|
| Circulatory disorders..... _____ | Mental disorders..... _____ | Thyroid problems..... _____ |
| Blood clots..... _____ | Neurological disorder.... _____ | Carpal Tunnel..... _____ |
| Thrombosis..... _____ | Numbing/tingling..... _____ | Hand/wrist pain..... _____ |
| Phlebitis..... _____ | Loss of sensation..... _____ | Digestive problems..... _____ |
| Varicose veins..... _____ | Memory loss..... _____ | Respiratory problems.... _____ |
| Heart disease..... _____ | Learning disorder..... _____ | Low back pain..... _____ |
| High blood pressure..... _____ | Hallucination..... _____ | Spinal pain..... _____ |
| Low blood pressure..... _____ | Visual disorder..... _____ | Diabetes..... _____ |
| Dizzy spells..... _____ | Trembling..... _____ | Stroke..... _____ |
| Arthritis..... _____ | Audio disturbance..... _____ | Skin irritations..... _____ |
| Osteoporosis..... _____ | Closed head injury..... _____ | |

Please list any medications you are currently using. _____

Are you presently under the care of a medical physician/chiropractor/therapist? If yes, please explain.

Are you receiving care from a psychologist, social worker/counselor? If yes, please explain. _____

Do you have chronic body discomfort? If yes, please explain. _____

Past accidents, injuries, or broken bones? Surgeries? _____

What are your current exercise programs, and/or special diet? _____

Do you use alcohol, tobacco, or caffeine? If yes, please specify. _____

I certify the above information is true.

Signature: X _____ Date: _____