Oasis Massage
Fibromyalgia Initial Questionnaire

Client Name: _____

Describe your typical pain sensation: _____
Does your pain level change from day to day? ❒ Yes ❒ No
Where/when do you typically feel pain?_____
How often does the location of the pain change? _____
What typically triggers a flare-up*?* _____
Do you have fatigue? ❒ Yes ❒ No If yes, please describe: _____
_____

Describe your sleep patterns:
Are you able to fall asleep easily? ❒ Yes ❒ No
Do you wake up throughout the night? ❒ Yes ❒ No
How do you feel when you wake up in the morning? ❒ Yes ❒ No
Do you have sensitivity to environmental stimuli, like ❒ sounds ? ❒ odors? ❒ light? ❒ N/A
Do you have the following related conditions: ❒ Anxiety ❒ IBS ❒ Jaw Pain
❒ Chronic Headaches ❒ Migraine Headaches ❒ Depression
❒ Other:_____
What type of doctors do you see for this condition?

Name	*Specialty*	*Phone Number*

Are you taking medications for this condition? ❒ Yes ❒ No If yes, please list.

Medication	*Dosage/Frequency*	*Side Effects, if any*

What other alternative therapies do you receive? _____
Have they helped? ❒ Yes ❒ No If yes, how? _____

What lifestyle changes have you made to manage your condition?_____
_____
Describe your overall feelings toward fibromyalgia & how it affects your daily life:_____
_____
Describe your overall treatment plan for managing your condition:_____
_____

Client Signature: _____Date: _____