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| Original Date: | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| Revision Date: | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| CLIENT QUESTIONNAIRE |
| ***Please print all information legibly******All answers contained in this questionnaire will be kept strictly confidential*** |
| Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 M🞎 F | DOB \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Home Phone (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City/ST/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Cell Phone (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| I would like my appt. verifications to come via:  |
|  🞎 cell phone texts. My cell phone service provider is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| 🞎 email. My email address is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞎 Please put me on your email list to receive promotions and any updates on your services. |
| Have you eaten in the last 4 hours? 🞎 Yes 🞎 No (If not, you may experience light-headedness after the massage) |
| I certify that I am currently not under the influence of any narcotics or alcohol. I understand that it can be life-threatening if massage is received while under the influence of these substances. Client initials \_\_\_\_\_\_\_ |
| How did you learn about our services?: *Circle one* Advertisement Web Search on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Friend: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we send them a thank you? 🞎 Yes 🞎 No |
| Family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we send them a thank you? 🞎 Yes 🞎 No  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you ever had a massage? 🞎 Yes (Date of Last Massage \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_) 🞎 No |
| What are your goals for this massage session? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| PERSONAL HEALTH HISTORY |
| Within the past 5 years, have you had any injuries which required medical attention? 🞎 Yes 🞎 No  If yes, describe: |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Within the past 5 years, have you had any surgeries? 🞎 Yes 🞎 No If yes, describe: |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you currently taking medication? 🞎 Yes 🞎 No If yes, describe medication and when typically taken: |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| List, including frequency of use, all remedies, herbs, and supplements you use. |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Check if you currently have, or have had, any problems in the following areas to a significant degree and briefly explain. |
| 🞎 Skin 🞎 Neck  | 🞎 Ears 🞎 Back  | 🞎 Intestinal 🞎 Bowel  |
| Do you have, or have you ever had significant problems with any of the following (Circle those that apply): |
| Joints: | Disorders/Diseases: | Body Fluids: | Musculoskeletal:  |
| Rheumatoid Arthritis  | Sleep Apnea | High/Low Blood Pressure | Bursitis |
| Osteoarthritis  | Depression/Anxiety | Hypo/ Hyperthyroid | Tendonitis |
| Joint stiffness or swelling | Fibromyalgia | Lymphedema | Congenital/Flexible flat feet |
| General Well-being: | Heart disease | Stroke | Bunion |
| Chronic pain | Asthma | Varicose veins | Swollen ankles |
| Fatigue | Cancer | Spinal cord injury | Fractured bones |
| Insomnia | Diabetes | Blood clots | Plantar Fasciitis |
| Headaches/Migraines | Epilepsy | Cardiac/Circulatory Problems | Breast Augmentation/ Reduction |
| Jaw pain/TMJD | Multiple Sclerosis |  |  |
| Allergies/Sensitivities(Seasonal/Lotions/Oils/Scents) | Parkinson’s disease |  |  |
| Do you have any fungal infections (i.e., plantar warts) or open wounds? 🞎 Yes 🞎 No (Stating “yes” will not cancel your appointment; we will just need to take precautions) |
| Females - *Are* you Pregnant? 🞎 Yes 🞎 No Months: *Could* you be Pregnant? 🞎 Yes 🞎 No Massage is NOT recommended during the first trimester due to pressure points which can cause the uterus to contract and could cause miscarriage. *A waiver will need to be signed for the massage to take place.* |
| Do you wear contact lenses? 🞎 Yes 🞎 No Dentures? 🞎 Yes 🞎 No Hearing aid? 🞎 Yes 🞎 No  |
| Are you currently being treated by a Physician? 🞎 Yes 🞎 No |
|  If yes, for what ailment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Are you currently being treated by a Chiropractor? 🞎 Yes 🞎 No |
|  If yes, for what ailment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you currently being treated by any other Healthcare Practitioner? 🞎 Yes 🞎 No |
|  If yes, for what ailment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| Are you ticklish or do you have any areas that are hypersensitive to touch? 🞎 Yes 🞎 No  |
| If yes, where? :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have any difficulty lying on your: 🞎 front, 🞎 back, or 🞎 side? 🞎 No  |
| Do you sit for long hours at a 🞎 computer, or 🞎 driving? # hrs/day \_\_\_\_\_\_\_\_ 🞎 No  |
| Do you perform any repetitive movement in your 🞎 work, 🞎 sports, or 🞎 hobby? 🞎 No  |
|  What is the repetitive movement? :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you regularly experience a significantly high level of stress? 🞎 Yes 🞎 No  |
|  If yes, do you think it has affected your health in any of the following ways? |
|  🞎 muscle tension 🞎 anxiety 🞎 insomnia 🞎 irritability 🞎 other: |
| Are there any questions or comments you wish to discuss prior to your massage?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Circle any specific areas you would like the massage therapist to concentrate on during the session:

Therapist’s Notes:

**AGREEMENTS OF LICENSED MASSAGE THERAPIST AND CLIENT**

**The Licensed Massage Therapist Agrees to the Following:**

I do not diagnose illness, disease or any other physical, mental or emotional disorder. As such, I do not prescribe medical treatment(s) or medication(s), nor do I perform any spinal manipulations.

***Any and all conversations during massage session related to client’s medical condition or history are kept under strict confidentiality. This confidentiality will be honored unless the massage therapist receives written permission from the client to disclose information to a third party, the client divulges thoughts that are harmful to him-/her- self or others, or if she is subpoenaed by a court or federal official.***

**Patient Agrees:**

I understand that massage therapy is given for the purpose of stress reduction, relief from muscular tension or spasm, and for increasing circulation and energy flow. Massage services are designed to be a health aid and are in no way to take the place of a doctor’s care. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Information exchanged during any massage session is intended to help me become more familiar and conscientious of my own health status. I agree to keep my massage therapist updated as to any changes in my client profile and understand there shall be no liability on the massage therapist’s part should I forget to do so.

Massage therapy is not a substitute for medical diagnosis or treatment and I should consult a physician for any ailments I may have. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly and to the best of my ability.

Finally, I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

**CANCELLATION POLICY**

We understand that unanticipated events happen occasionally in everyone’s life. In our desire to be effective and fair to all our clients and out of consideration for our therapists’ time, we have adopted the following policies:

* **24-hour advance notice is required when cancelling an appointment.** This allows the opportunity for someone else to schedule an appointment. You will be required to pre-pay for future appointments (no refund will be given should you fail to give 24 hour notice on pre-paid appointments).
* **No-Shows**. Should you miss your appointment or fail to give the required 24 hour notice, you will be required to pre-pay for future appointments (no refund will be given should you miss a pre-paid appointment).
* **Late Arrivals.** Appointment times have been arranged specifically for you. If you arrive late your session will be shortened in order to accommodate others whose appointments follow yours. Depending on how late you arrive, your therapist will determine if there is enough time remaining to start a treatment. **You will still be responsible for the payment of the full session.**

*These policies have been put into place out of respect and consideration for your therapist and other customers.*

I have read and agree to the above terms and Cancellation Policy.

**Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Consent to Treatment of Minor:***

By my signature below, I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

**Signature of Parent or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **FOR OFFICE USE ONLY** |
| **Client Info Entered \_\_\_\_\_\_\_\_\_\_**  | **Medical Hx Entered \_\_\_\_\_\_\_\_\_\_** | **Thank You Mailed \_\_\_\_\_\_\_\_\_\_** |