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 _____/_____/_____

Phone: Home (_____)_____Cell (_____)_____

Occupation _____ Email: _____

Emergency Contact:_____ Phone: _____

☐ Please send me appointment reminders via text message.

How did you learn about my services?: *Circle one* Advertisement _____

Friend: _____ Web Search on _____

Family: _____ Other: _____

Have you ever had a massage? ☐ Yes (Date of Last Massage _____/_____/_____) ☐ No

What are your goals for this massage session? _____

PERSONAL HEALTH HISTORY

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 _____

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:

_____

_____

List, including frequency of use, all home remedies, herbs, and supplements you use.

_____

_____

_____

Check if you currently have any problems in the following areas to a significant degree and briefly explain.

☐ Skin _____ ☐ Ears _____ ☐ Intestinal _____

☐ Neck _____ ☐ Back _____ ☐ 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		Sciatica
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; I will just need to wear gloves)

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? _____

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?

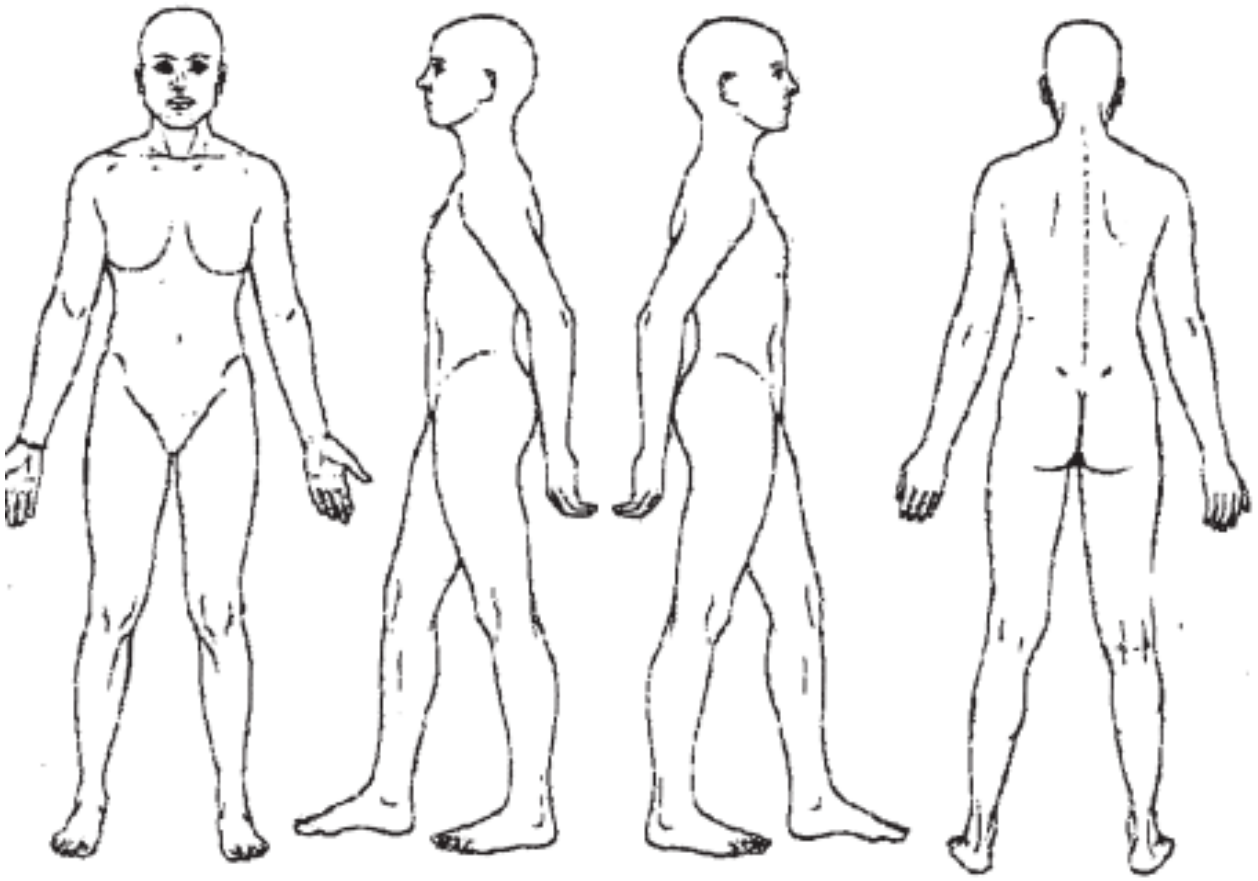
☐ muscle tension ☐ anxiety ☐ insomnia ☐ irritability ☐ other:

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 that was scheduled.**

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 _____