

Client Questionnaire

In order to maximize the effectiveness and safety of our sessions we ask that you take the time to fill out this confidential questionnaire.

Name _____ Date _____

Referred by _____

Address _____

Phone (day) _____ (eve) _____ Date of Birth _____

Occupation(s) _____

What brings you here today?

Is there any area where you would like extra time spent? Is there any area where you have muscle pain/stiffness/tension (neck, low back, shoulder, other?)

What is your previous experience with professional massage?

Habits: Exercise _____

Tobacco _____ Alcohol _____

Drugs (non-med) _____

Posture assumed most of the day _____

Caffeine _____ Sleep _____ Bowels _____

Medical History: Please indicate below any significant medical problems, as such conditions can influence the type and/or depth of work done in any given area.

_____ Skin condition (acne, rash, allergies, skin cancer, other)

_____ Lymphatic condition (swollen glands, lymphoma, lymphedema, other)

_____ Recent Injury (whiplash, sprain, deep bruise, other)

_____ Circulatory condition (heart disease, varicose veins, arrhythmias, arteriosclerosis, other)

_____ Neurological condition (sciatica, numbness/tingling of any area of skin, stroke, epilepsy, other)

_____ Joint problems, pain, or stiffness (osteoarthritis, rheumatoid arthritis, gout, hypermobile joints, sacroiliac problems, other)

_____ Bone conditions (osteoporosis, previous fracture, cancer, other)

_____ Headaches (migraines, PMS, tension, cluster, other)

_____ Emotional difficulties (depression, anxiety, psychotic episodes, other)

_____ Stress

_____ Previous surgery, please state type and date

_____ Other

_____ List any medications you are currently taking

Healthcare provider _____ Phone: _____

Do we have your permission to contact him/her should the need arise?

Your signature _____ Date _____