

### Client Questionnaire

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

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (day): \_\_\_\_\_ (eve): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation(s): \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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?

Daily activities / sports / hobbies: \_\_\_\_\_

Habits: Exercise (types and frequency) \_\_\_\_\_ Sleep \_\_\_\_\_  
Tobacco \_\_\_\_\_ Alcohol \_\_\_\_\_ Drugs (non-med.) \_\_\_\_\_ Caffeine \_\_\_\_\_  
Posture assumed most of day \_\_\_\_\_ 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. Thank you.

- \_\_\_\_\_ Allergies
- \_\_\_\_\_ Skin condition (acne, rash, allergies, skin cancer, other):
- \_\_\_\_\_ Lymphatic condition (swollen glands, lymphoma, lymphedema, other):
- \_\_\_\_\_ Recent injury or accident (whiplash, sprain, deep bruise, other):
- \_\_\_\_\_ Circulatory condition (heart disease, varicose veins, phlebitis, arrhythmia, 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):
- \_\_\_\_\_ Can you lie comfortably on your stomach? \_\_\_\_\_ Can you lie comfortably on your back? \_\_\_\_\_
- \_\_\_\_\_ 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 medical considerations:
- \_\_\_\_\_ List any medications you are currently taking:
- \_\_\_\_\_ Are you pregnant?
- \_\_\_\_\_ Do you have any body piercings that would be effected by heat (such as belly piercings)?

Name of Health Care provider (not Insurance Co.): \_\_\_\_\_

Do we have permission to contact him/her should the need arise? Yes \_\_\_\_\_ No \_\_\_\_\_