CLIENT QUESTIONNAIRE
Confidential Information

Name _____ **Referred by** _____

Address _____ **City** _____ **State** _____**Zip** _____

Phone _____ **Email Address** _____

Occupation _____ **DOB** _____

- Have you ever received a professional massage before? ☐ Yes ☐ No
- If "yes", how long ago was your last massage? _____
- Is there any area(s) where you would like extra time spent? _____
- Is there any area(s) where you have muscle pain/stiffness/tension? _____

_____

- What type of pressure do you prefer? Light _____ Medium _____ Firm _____

Do you have a history of the following?

☐ recent injury/accident	☐ tendinitis/bursitis	☐ abdominal pain
☐ neck pain	☐ sciatica	☐ surgery _____
☐ whiplash	☐ high blood pressure	☐ current infectious disease
☐ headaches	☐ stroke	☐ stress
☐ disc problems	☐ heart disease	☐ emotional difficulties
☐ back pain	☐ cancer	☐ seizures
☐ joint pain/problems	☐ diabetes	☐ allergies to oils/perfumes
☐ decreased range of motion	☐ varicose veins	☐ skin condition
☐ sprains/strains	☐ circulatory problems	☐ wear contacts/dentures/hearing aid
☐ bone condition	☐ lymphatic condition	☐ other _____

Do you have any of the following today?

☐ sunburn	☐ headache	☐ open cuts/bruises/burns
☐ inflammation	☐ irritated skin rash	☐ cold/flu
☐ severe pain	☐ poison ivy	☐ fever

- Are you currently under the care of a physician or other health care professional? ☐ Yes ☐ No

If you answered "Yes":

- For what condition? _____

If at any time you have any questions regarding your session, please let me know.

Client Signature _____ Date _____