Comfort Zone Massage, LLC

Client Questionnaire

Personal Information

Today's Date _____

First Name _____ Last Name _____ Birth Date _____

Gender [Circle] Female Male Not Specified Occupation _____

Contact Information

Email _____ Cell Phone _____ Other Phone _____

Address _____ City/State Zip_____

In case of emergency who do we contact? _____ Telephone _____

How did you hear about us? _____ Have you had a professional massage? YES NO

Physician Name _____ Phone _____

Issues to Address Information

Cause of Injury or Concern: _____ First Noticed _____ OR Not Applicable

Therapist to ASK: Your treatment goals? Past Treatment?

Please review this list and circle any illness and/or medical conditions may apply:

Respiratory:	Asthma	Bronchitis	Chronic Cough	Emphysema	Short Breath
Cardiovascular:	Clots	Cold Hands	High Blood Pressure	Pacemaker	Varicose Veins
	Cardiovascular Accident		Congestive Heart	Stroke	Phlebitis
	Cerebral-vascular Accident		Heart Attach	Lymphedema	Low Blood Pressure
	Thrombosis/Embolism		Cold Feet	Heart Disease	Myocardial Infarction
Skin:	Bruise Easily	Skin Irritations	Hypersensitive	Melanoma	Skin Conditions
Head/Neck:	Headaches	Ear Problems	Sinus Problems	Hearing Loss	Vision Loss
		Jaw Pain [TMJ]	Migraines	Vision Problems	
Infectious Conditions:		Athlete's Foot	Hepatitis	Herpes	HIV
		Respiratory Conditions	Skin Conditions		
Women:	Gynecological Conditions		Pregnancy		
Soft Tissue/Joint Dysfunction:		Ankles [Left/Right]	Arms [Left/Right]	Feet [Left/Right]	Hands [Left/Right]
		Hips [Left/Right]	Knees [Left/Right]	Legs [Left/Right]	Low Back [Left/Right]
		Mid Back [Left/Right]	Neck [Left/Right]	Shoulders [Left/Right]	
		Upper Back Shoulders [Left/Right]			
Family History:		Cardiovascular Conditions	Respiratory Conditions		
Neurological:		Burning	Cerebral Palsy	Herniated Disc	Multiple Sclerosis
		Numbness	Parkinson's	Stabbing Pain	Tingling

OVER…

Miscellaneous:

Allergies	Anaphylaxis	Artificial Joints	Arthritis	Cancer
Crohn's Disease	Epilepsy	Diabetes	Dizziness	Gout
Digestive Problems	Hemophilia	Insomnia	Fibromyalgia	Lupus
Mental Illness	Osteo Arthritis	Loss of Sensation	Shingles	Stress
Rheumatoid Arthritis	Osteoporosis	Surgical Pins/Wire		
Other Medical Conditions	Other Diagnosed Diseases			

Any known allergies (nuts, oil etc…)_____

Please list any medication or drugs you are currently on:

Client Waiver Form [Please take a moment to read and initial the following information]:

- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that the services offed today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.
- I understand that massage is entirely therapeutic and non-sexual in nature.
- I understand that, because massage therapy work involves maintained touch and close phy6sical proximity over an extended period, there may be an elevated risk of disease transmission, including COVIS-19.
- I understand that hot stones may be used during my therapy treatment and that I may request a complete disclosure of the use of hot stones upon request or on the Comfort Zone website.
- By signing this release, I hereby waive and release my therapist from any 0and all liability, past, present, and future relating to massage therapy and bodywork.

Disclosures:

While we are aware that emergencies occur, please know that your appointment covers a 60-minute time slot in our book. Your consideration in letting us know ahead of time of any problem will allow us to schedule another person. Thank you.

Cancellation Policy: Please give us 12-hours' notice if you need to cancel or reschedule.

Lateness Policy: If you are late for your appointment, we may need to shorten your session or reschedule your appointment so that we can stay on time for others. If we are late, you will receive your full time.

No Show Policy: First time we will attempt to work with you. The second time, you will be asked to pay 50% of the session. Any time thereafter, you will be billed at the full price of the session.

I have read the statement above and agree to all the policies. _____ Initials

Client/Guardian Signature _____ Date _____

Therapist Signature _____Date _____

OFFICE ONLY:
____ Welcome ____ Thank You
____ Input ____ Accounting