Hands-On Therapy Center for Body, Mind & Spirit

In order to maximize the effectiveness and safety of massage sessions together, please take the time to carefully fill out this questionnaire. This information will be treated confidentially. Use back of page if extra space is needed. Your feedback is appreciated during and at the end of sessions to help in tailoring the massage session to serve in the best possible way.

Client Contact Information

Name:_________________________________ Date of 1st Visit: ______________

Address: ____

Telephone: ____________________ Email: _______________________________

Occupation(s)_____________________ Date of Birth: _______________________

How did you hear about me?____

General & Medical Information

Have you received a massage before? Y / N

Have you had any serious surgeries/fractures in the past 6 months? Y / N

If yes, please specify:

____

Are you currently taking any medication or supplements? Y / N

Please list conditions they treat:

____

Do you exercise? Y / N Specify:

____

How much plain water do you consume daily? ________________________________

Rate your stress level on a scale of 1-4 (1=low stress, 4=high stress) ______________

What kind of pressure do you enjoy during a massage?

Light **Medium** **Deep** **Not Sure**

What would you like to achieve from your massage?

Relaxation **Relief from muscle pain** **Other:**

____

What area(s) would you like focused on during your massage?

____

Please check the following that apply:

___Allergies	___Fibromyalgia	___Numbness
___Varicose Veins	___Cancer	___Seizers
___Tendonitis	___Easy bruising	___Insomnia
___Pacemaker	___Tingling	___Headaches/migraines
___Sore muscles	___Sciatica	___Inflammation
___Diabetes	___Arthritis	___Disc problem
___Mental illness	___Sprain/strain	___High or Low blood pressure
___Pregnancy 1 2 3		

Explain any issues from above:

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I acknowledge that the information I have provided is complete and accurate. In the case of adverse effects of my massage, I agree not to hold my massage therapist liable. If I, the client, experience any pain or discomfort during my session, I will immediately inform the therapist so that the treatment can be modified to my comfort level. I affirm that I have honestly answered all questions and stated known medical conditions. I agree to inform the therapist of any changes in my medical profile, I understand the therapist is not liable if I fail to inform them of any problems.

I understand that the therapist has the right to terminate the massage at any time if they determine it is not safe for me, or the therapist to continue.

Client's Signature: ________________________________ Date: ______________

Please circle any problem areas