Massage Therapy 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.

First/Last Name: _____ Date: _____ Referred by: _____
Address: _____
Phone (day): _____ (eve): _____ Date of Birth: _____
Occupation(s): _____
Age: _____ Height: _____Weight: _____ Build: _____

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 affected by heat (such as belly piercings?
Name of Health Care provider (not Insurance Co.):_____

Phone:_____
Do we have permission to contact him/her should the need arise? Yes_____ No _____

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapist Association of California, Inc.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing.

I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks. I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my health history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third-party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.
I HAVE READ, UNDERSTOOD, and AGREE to the above consent.

SIGNATURE: _____ DATE: _____

MISSED APPOINTMENT / CANCELLATION POLICY
Your appointment time is reserved especially for you. If you are unable to keep your allotted time, we kindly ask that you give us a minimum of 24-hour advance notice in order for us to give our therapists a reasonable amount of time to fill the appointment slot.

Because our therapists get affected directly when appointments are missed, or when appointments are cancelled with less than 24-hour notice, we will charge $30 for the time booked. This amount must be paid prior to your next scheduled appointment.

If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of treatment actually given, you will be responsible for the full session.

Please understand that appointment reminders are a courtesy. In the event that we were unable to contact you, you are still responsible for showing up at your allotted treatment time. Our therapists also gratefully respect you and your time. We understand that all our patients have busy lives and, as such, our therapists will make sure that all appointments begin and end on time.

I HAVE READ, UNDERSTOOD, and AGREE to the above policy.

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____