Back in Touch Wellness Center LLC

CLIENT QUESTIONAIRE

Thank you for choosing Back in Touch!

To maximize the effectiveness and safety of our session(s) together,
we ask that you take the time to fill out this confidential questionnaire carefully.

Contact Information:

Name: _____ Address:_____
(Street) (City) (Zip)

Phone Number: _____ _____ _____
(Home) (Work) (Cell)

E-Mail: _____

ABOUT YOU:

Age: _____ Height: _____ Weight: _____ DOB: _____ Occupation(s): _____
What brings you here today? _____Who referred you? _____
What do you do to relax? _____
What is your previous experience with professional massage? _____
Is there any area where you would like extra time spent? Is there an area where you have muscle pain, stiffness, or tension? _____
Do you have difficulty lying on your back or stomach? _____ Allergic to oils? _____

HABITS:

Exercise: _____ Daily Posture: _____
Tobacco? _____ Alcohol? _____ Drugs? _____ Caffeine? _____ Sleep? _____ Bowels? _____
(Non – Prescribed)

Medical History:

Please indicate below any significant medical problems; these conditions can influence the type and/ or depth of work done in any given area.

_____ Skin condition (Acne, Rash, allergies, Skin cancer, other)
_____ Lymphatic condition (Swollen Glands, Lymphoma, other)
_____ Recent Injury (Whiplash, Sprain, Deep Bruise, other)
_____ Circulatory Condition (Heart Disease, Varicose Veins, Phlebitis, Arrhythmias, Arteriosclerosis, other)
_____ Neurological Condition (Sciatica, Numbness, Tingling of any area of skin, Stroke, Epilepsy, other)
_____ Joint Problems, Pain/ Stiffness (Osteoporosis, Previous Fracture, Cancer, Other)
_____ Bone conditions (Osteoporosis, Previous Fracture, Cancer, Other)
_____ Headache (Migraines, PMS, Tension, Cluster, Other)
_____ Emotional Difficulties (Depression, Anxiety, Psychotic Episodes, Other)
_____ Previous Surgery – Please state type and date: _____
_____ Other: _____

Please list any medications you are currently taking: _____
Primary Care Physician: _____ Phone: _____ Town: _____
Do we have your permission to contact your Physician if the need should arise? _____
Anything else you think we should know about you? _____

Your Signature: _____ Date: _____

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POLICY AND AGREEMENT

The Massage Practitioner does not diagnose, treat, prescribe for or offer medical service for any disease, illness or other physical disorder of a person. Nothing said in the course of the massage session should be misconstrued as such. This agreement is provided to help clarify the professional boundaries of massage therapy in the state of Connecticut, and make it known that Massage Practitioners, unless holding degrees as such, are not trained medical doctors, chiropractors, or physical therapists.

I understand that I am responsible for alerting the therapist to any physical, medical, and or emotional conditions I am aware of that may impact his/her decisions regarding if and how to provide massage therapy. I also understand that I am responsible for communication any physical or emotional discomfort, should any arise, during the session so that appropriate adjustments can be made.

I also understand that the therapist has set aside agreed to appointment time for my specific use and agree to pay the full fee for the session if I fail to cancel within 24 hours of the appointment time as this policy is in keeping with that of m any other providers of personal services.

My signature below acknowledges that I have read, understand, and agree with the above statement.

_____ _____

(Signature) (Date)