

MESSAGE/BODY WRAPS: CLIENT QUESTIONNAIRE

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Email _____

Phone (home) _____ (work) _____ (cell) _____

Occupation _____ DOB _____

Do you have any seafood allergies? ____ Yes ____ No

Have you had a professional massage before, and if so, approximately how many times?

Do you have any physical problems with you body (injuries or otherwise) or any areas of acute pain or inflammations/diseases (incl. Varicose veins/arthritis/joint swelling, osteoporosis or allergies) that I should be conscious of or avoid before giving you the massage?

Are you taking any prescription medications for problems such as diabetes, heart problems, high blood pressure, epilepsy or seizures, etc.?

Have you ever been in an accident or broken any bones in the last 2 years?

Are there any areas that I should avoid when giving you a massage, either for medical reasons, or because you bruise easily, or for personal reasons?

Are there any areas of your body that you would like me to focus more time on during the massage (face, scalp, neck, shoulders, upper back, lower back, arms, hands, gluts, legs, feet)? On a scale of 1-10 (1 being the least, 10 being the worst), where do you rate your pain in these specific areas?

Pressure: Which would you prefer? LIGHT MEDIUM DEEP

End of massage:

What part of the massage did you find particularly therapeutic or stress relieving (enjoy the most)?

What part of the massage did you enjoy least or were any techniques expected or desired that you did not receive?

Signature _____ Date _____

Massage Therapist Signature _____ Date _____