Serenity Holistic Massage

Client Questionnaire

Basic Information			
First Name	Last Name	Date of Birth	Sex
			☐ Male ☐ Female ☐ Other ☐ Not Specified

Contact Information			
Email	Preferred Phone		
	☐ Cell ☐ Landline		
Address	City	State	Zip

Emergency Contact Information		
Contact Name	Phone	Relationship

Complaints
Cause of Injury or Concern
How long since first noticed?
Primary Complaint (Describe briefly what symptoms you're experiencing and where.)
Past Treatment

Respiratory			
☐ Asthma	☐ Bronchitis	☐ Chronic Cough	☐ Emphysema
☐ Shortness of Breath			

Cardiovascular			
☐ Blood Clots	☐ Cardiovascular Accident	☐ Cerebral-Vascular Accident	☐ Cold Feet
☐ Cold Hands	☐ Congestive Heart Failure	☐ Heart Attack	☐ Heart Disease
☐ High Blood Pressure	☐ Low Blood Pressure	☐ Lymphedema	☐ Myocardial Infarction
☐ Pacemaker	☐ Phlebitis	☐ Stroke	☐ Thrombosis/Embolism
☐ Varicose Veins			

Skin			
☐ Bruise Easily	☐ Hypersensitive reaction	☐ Melanoma	☐ Skin Conditions
☐ Skin Irritations			

Head and Neck			
☐ Ear Problems	☐ Headaches	☐ Hearing Loss	☐ Jaw Pain (TMJD)
☐ Migraines	☐ Sinus Problems	☐ Vision Loss	☐ Vision Problems

Infectious Conditions			
☐ Athlete's Foot	☐ Hepatitis	☐ Herpes	☐ HIV
☐ Respiratory Condition	☐ Skin Conditions		

Women			
☐ Gynecological Conditions	☐ Pregnancy		

Soft Tissue/Joint Dysfunction			
☐ Ankle (Left)	☐ Ankle (Right)	☐ Arm (Left)	☐ Arm (Right)
☐ Feet (Left)	☐ Feet (Right)	☐ Hands (Left)	☐ Hands (Right)
☐ Hips (Left)	☐ Hips (Right)	☐ Knees (Left)	☐ Knees (Right)
☐ Legs (Left)	☐ Legs (Right)	☐ Lower Back (Left)	☐ Lower Back (Right)
☐ Mid Back (Left)	☐ Mid Back (Right)	☐ Neck (Left)	☐ Neck (Right)
☐ Shoulders (Left)	☐ Shoulders (Right)	☐ Upper Back (Left)	☐ Upper Back (Right)

Family History

☐ Cardiovascular Conditions	☐ Respiratory Conditions

Miscellaneous

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

Neurological			
☐ Burning	☐ Cerebral Palsy	☐ Herniated Disc	☐ Multiple Sclerosis
☐ Numbness	☐ Parkinsons	☐ Stabbing Pain	☐ Tingling

Medications: Please list any medications 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 offered 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.
- By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

☐ I have read the statement above and agree to all the policies therein

Signature:

Date: