Massage By Carey Client Questionnaire

Personal Information

Basic Information

First Name

Last Name

Date of Birth

Male Female Other Not Specified

Contact Information

Email

Preferred Phone

Cell

Address

City

State

Zip

Emergency Contact Information

Contact Name

Phone

Relationship

Doctor Information

Physician Name

Phone

Complaint Information

Cause of Injury or Concern

How long since first noticed

Primary Complaint

Past Treatment

Additional Questions

Describe any exercise, repetitive movement activities or hobbies you have.

Do you have any goals in mind for your massage sessions?

Are you wearing contact lenses, hearing aids or dentures?

Have you had a professional massage before? Is yes, how often?

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 Disease
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Heart Attack
- [ ] Myocardial Infarction
- [ ] Pacemaker
- [ ] Phlebitis
- [ ] Lymphedema
- [ ] Thrombosis/Embolism
- [ ] Varicose Veins
- [ ] Stroke

Skin

- [ ] Bruise Easily
- [ ] Hypersensitive Reaction
- [ ] Melanoma
- [ ] Skin Conditions
- [ ] Skin Irritations

Head & 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 Conditions
- [ ] Skin Conditions

Women

- [ ] Gynecological Conditions
- [ ] Pregnancy

Soft Tissue / Joint Dysfunction

- [ ] Ankles (Left)
- [ ] Ankles (Right)
- [ ] Arms(Left)
- [ ] Arms(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
- [ ] Osteo Arthritis
- [ ] Osteoporosis
- [ ] Other Diagnosed Diseases
- [ ] Other Medical Conditions
- [ ] Rheumatoid Arthritis
- [ ] Shingles
- [ ] Stress
- [ ] Surgical Pins or Wire

Allergies and other conditions your provider should be aware of

Neurological

- [ ] Burning
- [ ] Cerebral Palsy
- [ ] Herniated Disc
- [ ] Multiple Sclerosis
- [ ] Numbness
- [ ] Parkinsons
- [ ] Stabbing
- [ ] Tingling

Medications Please list any medications or drugs you are currently on

Additional Questions

List any past surgeries or injuries you've had.

Client Waiver form

Consent

- 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. Draping will be used during the session – only the area being worked on will be uncovered.
- A parent or legal guardian must accompany clients under the age of 17 during the entire session.

Cupping Therapy

- I understand any markings, discoloration, and redness to the skin will dissipate from a few hours to as long as two weeks and in relation to my after-care activities. I understand these markings are not injuries and not bruises.
- Information has been provided to me about Medi-Cupping Therapy. If I choose to experience these therapies during treatments, I understand the potential effects and after-care recommendations.

Financial

- Fees are listed on our website and posted in our office.
- You can find a copy of this Financial Agreement on our website.
- Payment is due when services are rendered.
- There is a $35 charge for all returned transactions including credit card & checks
- All customers are *required* to place a credit card on file.
- 100% of the full session fee will be charged if your scheduled appointment is NOT fulfilled because of:
  - "Missed" appointment- not showing for a scheduled appointment **OR** arriving more than 15 minutes after your scheduled appointment time.
  - "Late cancellation"- Not providing 24 hour notice prior to cancellation

Privacy & Security Notice

We protect your information using physical, technical, and administrative security measures to reduce the risk of loss, misuse, unauthorized access, disclosure and alteration. We use PCI (payment card industry) and HIPAA (health insurance portability and accountability act) security standards. Some of the safeguards we use

are firewalls and data encryption, physical access controls, and information access controls. We make every reasonable effort to protect our customers' private information and to store it securely in accordance with the above standards.

Waiver

- I hereby waive and release Massage By Carey and its entire staff, massage therapists and body work practitioners from any and all present and future liability, loss, cost, claim, or damage whatsoever, which may be imposed upon the company relating to massage therapy and bodywork; including but not limited to deep tissue therapy, neuromuscular therapy, kinesiotaping, cupping therapy, hot stone, reflexology, acupressure, energy work, nutritional therapies, all forms of kinesiology, aromatherapy, craniosacral therapy, myofascial release, trigger point therapy, stretching, strength and conditioning training.
- I further undertake to indemnify and hold Massage By Carey harmless from any incident(s) arising from my use of the Massage By Carey services.
- If I miss an appointment or provide late cancellation, I authorize Massage By Carey to charge 100% of the session fee using the credit card I have on file.

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

Client Signature*

Date*