Riverbend
THERAPEUTIC MASSAGE, LLC
Since 1990

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.

Date_____ Referred by_____

Name _____

Address _____

City _____ State _____ ZIP_____

Phone (day) _____(eve.)_____Date of Birth_____

E-mail: _____ Occupation(s) _____

Reason for appointment: _____

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? _____

_____

Personal Habits: Exercise_____

Tobacco ❑ Yes ❑ No Alcohol ❑ Yes ❑ No Caffeine ❑ Yes ❑ No # cups per day_____

Posture assumed most of day _____ Sleep: Good ❑ Poor ❑ # hours per night_____

Medical History: Please indicate below any significant medical problems, as such conditions can influence the type or depth of work done in any given area. Thank you.

_____ Skin condition (acne, rash, allergies, skin cancer), other: _____

_____ Lymphatic condition (swollen glands, lymphoma, lymphedema), 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 or stiffness (osteoarthritis, rheumatoid arthritis, gout, hypermobile joints, sacroiliac problems), other: _____

_____ Blood Pressure: ❑ Normal ❑ High ❑ Low

_____ Headaches (migraines, PMS, tension, cluster), other: _____

_____ Bone conditions (osteoporosis, previous fracture, cancer), other: _____

_____ Emotional difficulties (depression, anxiety, psychotic episodes), other: _____

_____ Stress

_____ Other (please explain): _____

_____ List any medications you are currently taking: _____ USE BACK SIDE IF NECESSARY →

Name of Health Care Provider (ie. Doctor): _____

Do we have permission to contact him/her should the need arise? ❑ Yes ❑ No Phone #_____

YOUR SIGNATURE _____ **OVER →**

Riverbend Therapeutic Massage

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 communicating any physical or emotional discomfort, should any arise, ***IMMEDIATELY DURING*** the session so that appropriate adjustments can be made. I hold neither Riverbend Therapeutic Massage, LLC, its owner, nor its massage therapists responsible for the aggravation of any conditions which are present but which I have failed to disclose prior to my receiving massage or other services. I also understand that the therapist may decline to provide service if she/he feels it is in the client's best interest. The therapist may also terminate a session early if a client behaves in an offensive or threatening manner.

Lastly, I understand that the therapist has set aside agreed-to appointment time for my specific use and ***I 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 many providers of personal services.

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

SIGNATURE_____ Date_____