A Healing Trail Wellness Center, LLC

Client Questionnaire For Therapeutic Massage, Acupuncture and Zero Gravity Float

Name _____ Date of Birth _____

***E*-mail** _____ Today's Date _____

Address _____City_____ State____ Zip_____

Home Phone _____ Cell phone or work phone_____
(for blizzard or emergency cancellations only)

Whom can we thank for referring you to us? _____

Occupation _____ My job requires: Driving - Standing - Computers - Sitting -Reaching
(Circle how you spend most of your time)

Have you ever received Professional Massage? Yes No How frequently? _____

In the past **5** years, have you had any injuries or problems with any of the following?

Y N Joint problems (Arthritis, hypermobile joints, gout...)

Y N Stress (job, home, illness, family)

Y N Bone conditions (fracture, cancer, osteoporosis...)

Y N Headaches (How often? _____) (migraine, cluster, tension, PMS...)

Y N Circulatory problems (easy bruising, clots, varicose veins, phlebitis, arteriosclerosis...)

Y N Lymph condition (lymphoma, swollen glands, lymphedema, cystic tissue...)

Y N Neurological condition (pinched nerves, sciatica, numbness or tingling in any area, stroke, epilepsy...)

Y N Emotional difficulties

Y N Skin conditions (any current rash, severe acne, herpes, allergies...)

Y N Diabetes (insulin dependent or oral medication only)

Y N Surgery of any kind (When_____Why?_____)

(Over for additional questions → → → → → → →)

Y N Heart conditions or High Blood Pressure

Y N Muscle conditions (strains, sprains, trigger points, tear...)

Y N Any recent injuries explain _____

Y N Pregnant - due date: _____Any related problems?_____

Y N Any food allergies or lotion reactions? _____

Y N Cancer (please state type, duration and treatment)_____

Y N Are you wearing contact lenses?

ANY other medical problems? _____

Are you currently taking ***any*** medications? Yes No What are they?_____

_____

_____

Your Habits: Exercise _____ Tobacco use_____

water intake / day _____ Alcohol intake _____ Caffeine use / day_____

Sleep pattern / night_____ Bowel frequency / day _____

Is there any body area where you would like **extra time** spent? (neck, low back, shoulder, legs, feet...?)

Is there any area you prefer **not** to have touched? (face, feet, abdomen, hair…?) Yes No

Does your doctor know you are receiving Therapeutic Massage or Acupuncture? Yes No

If needed, may we contact your Doctor regarding your medical condition(s)? Yes No

Cancellation Policy

We greatly appreciate as much notice as possible if you have to miss a scheduled appointment. We can usually fill your appointment with 48 hours notice. If you have to give less than 24 hours notice we would appreciate it if you would send a family member or friend in your place. If we can't fill your appointment when you have given less than 24 hours notice, we will bill you for 50% of the session fee.

Your initials here please _____

Doctor's Name and address_____

Your Signature_____

(Patient or Guardian)