NEW CLIENT QUESTIONNAIRE

The information you provide is for the sole use of The Center for Living Well Therapies for the purposes of tailoring your session to your specific needs and contacting you regarding your appointments.

The Center for Living Well Therapies
36A Padanaram Road
Danbury, Connecticut 06811
203.778.4544

DATE: _____

REFERRED BY:

- ☐ Friend / Relative: _____
- ☐ Website
- ☐ Google Search
- ☐ I Received a Gift Certificate
- ☐ I Don't Know

ABOUT YOU

NAME: _____ BIRTHDATE (mm/yyyy): _____

STREET/MAILING ADDRESS: _____

CITY: _____ STATE:_____ ZIP:_____

PHONE (Home): _____ (Mobile): _____ (Work): _____

E-Mail: _____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____

EMERGENCY PHONE:_____

Have you ever had a professional massage before? ☐ No ☐ Yes How often? _____

Do you have difficulty lying in any particular position? ☐ No ☐ Yes _____

Are you here because of injuries sustained in an accident? ☐ No ☐ Yes Date of Accident _____

This accident is: ☐ Work Related ☐ Motor Vehicle ☐ Other

Are you currently under the care of a physician for any health condition? ☐ No ☐ Yes _____

If "Yes," is your physician aware that you are seeking massage therapy? ☐ No ☐ Yes ☐ I don't know

Why have you sought out massage therapy services today?

☐ Pain Relief ☐ Relaxation ☐ Recommended by healthcare professional ☐ I have a Gift Certificate

PLEASE INDICATE ANY CONDITION(S) THAT APPLY TO YOU:

- ☐ Autoimmune Disease _____
- ☐ HIV/AIDS
- ☐ Open Sores
- ☐ Bruising
- ☐ Cancer / Malignancy
- ☐ Hepatitis
- ☐ Herpes I or II
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Arteriosclerosis
- ☐ Varicose Veins
- ☐ Phlebitis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Headaches
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Skin Rash
- ☐ Inner Ear Problems
- ☐ Wear Hearing Aids
- ☐ Wear Dentures
- ☐ Wear Contacts
- ☐ Wear Prosthesis
- ☐ Herniated Dis(s)
- ☐ Allergies
- ☐ Anxiety
- ☐ Depression
- ☐ Stress
- ☐ Mental Illness
- ☐ Recent Injury
- ☐ Recent Surgery

WOMEN:

☐ PMS ☐ Painful Menstruation ☐ Osteoporosis ☐ Pregnant: Weeks _____

CONTINUED ON NEXT SIDE…

SERVICES RELEASE

I understand that the Massage Therapy given me is for the purpose of relaxation, stress reduction, pain reduction, and relief from muscle tension, increasing circulation or other specific reasons as noted within this questionnaire. I further understand that Massage Therapy does not diagnose illness or disease or any other disorder and that the Massage Therapist does not prescribe medical treatment nor are spinal manipulations part of Massage Therapy. I understand that Massage Therapy is not a substitute for medical examinations or medical care and that it is recommended that I am working concurrently with my primary caregiver for any condition that I may have. **Because Massage is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all my known medical conditions and have answered all questions honestly.** I agree to keep the Massage Therapist updated as to any changes in my medical profile and I understand that there shall be no liability on the Massage Therapist's part should I fail to do so.

Please sign your name below if you understand the information stated in this release and that all information you have provided is true and accurate to the best of your knowledge. If you are under the age of 18 (eighteen) years old, the signature of a parent or legal guardian is required.

_____ _____

Client Signature or Guardian Signature if Client is a Minor — Date

_____

Print Client's Name

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

The Center for Living Well Therapies (CLWT) has put in place preventative measures to reduce the spread of COVID-19; however, CLWT cannot guarantee that you will not become infected with COVID-19. Further, receiving personal services (such as massage therapy) could increase your risk of contracting COVID-19 given the necessity of close proximity between client and practitioner.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by receiving these services and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at CLWT may result from the actions, omissions, or negligence of myself and others, including, but not limited to, other individuals who enter the facility. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with entering the facility and receiving services. I hereby release, covenant not to sue, discharge, and hold harmless CLWT, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of CLWT, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after receiving services.

_____ _____

Client Signature or Guardian Signature if Client is a Minor — Date

_____

Print Name of Client