The Center for Living Well Therapies
304 Federal Road, Suite 313
Brookfield, CT 06804
203.778.4544

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.

DATE: _____

REFERRED BY:

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

ABOUT YOU

NAME: _____ AGE: _____

MAILING ADDRESS: _____

CITY: _____ STATE:_____ ZIP:_____

PHONE: _____ M / H 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
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Skin Rash
- ☐ Inner Ear Problems
- ☐ Wear Hearing Aids
- ☐ Wear Dentures
- ☐ Wear Contacts
- ☐ Wear Prosthesis
- ☐ Pregnant: Weeks _____
- ☐ Herniated Disc(s)
- ☐ Allergies
- ☐ Anxiety
- ☐ Depression
- ☐ Stress
- ☐ Mental Illness
- ☐ Recent Injury
- ☐ Recent Surgery
- ☐ Other _____

Because Massage is contraindicated (should not be done) under certain medical conditions, I affirm that I have truthfully stated all of my known medical conditions and have answered all questions honestly and to the best of my ability. 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.

_____ _____

Client Signature or Guardian Signature if Client is a Minor

Date

Rev. July 24, 2022