

Screening Questionnaire



Name _____ Date _____

Home (____) _____ Work (____) _____ Cell (____) _____

Best time(s) to call _____ E-mail _____

Address _____

Occupation _____ Work hours _____

How did you hear about me? Who referred you? _____

Reason for calling/Purposes of Massage (relaxation/addressing an injury) _____

Description of injury _____

Contraindications _____

Is this a gift? Will anyone else be attending? _____

Have you previously had a massage? YES NO If so, by whom? _____

When? _____ Frequency? _____ Modality used? _____

Expectations _____

Communication checklist with client:

- | | | |
|---|--|--|
| <input type="checkbox"/> Nonsexual/draping | <input type="checkbox"/> Clothing/shiatsu | <input type="checkbox"/> Special needs/other _____ |
| <input type="checkbox"/> Food, drugs, alcohol | <input type="checkbox"/> Confidentiality | _____ |
| <input type="checkbox"/> Oils/lotions/allergies | <input type="checkbox"/> Cancellation/no-show policy | _____ |
| <input type="checkbox"/> Sanitation | <input type="checkbox"/> Late arrival policy | |
| <input type="checkbox"/> Fees/payment | <input type="checkbox"/> Work setting | <input type="checkbox"/> Sent packet on _____ |

What questions or concerns might you have? _____

If outcall, are there directions, parking, or special instructions? _____

Notes _____

