Eastern Therapeutic LLC

Client Questionnaire

In order to maximize the effectiveness and safety of our sessions together, please take the time to fill out this confidential questionnaire carefully.

Name:_____Date:_____Referred by:_____

Address:_____

Phone(cell):_____(home):_____

E-mail:_____Date of Birth:_____

Occupation(s):_____

What brings you here today?_____

Where do you tend to store tension? _____

Do you experience any difficulty in lying on your front or back?_____

What is your previous experience with professional massage?_____

Habits / Exercise:_____

Tobacco:_____Alcohol:_____Drugs (non-medical):_____Coffee:_____

Posture assumed most of day:_____Sleep position:_____

Do you wear: Contact lenses:_____Dentures:_____Hearing aid(s):_____

Please check if you are experiencing or have experienced any of the following conditions:

_____Bone condition (cancer, osteoporosis, previous fracture, other):_____
_____Circulatory condition (arrhythmias, arteriosclerosis, heart disease, phlebitis, varicose veins, other):
_____
_____Emotional difficulties (anxiety, depression, psychotic episodes):_____
_____Headaches (cluster, migraines, PMS, tension, other):_____
_____Joint problems, pain or stiffness (gout, hypermobile joints, osteoarthritis, rheumatoid arthritis, ruptured discs, other):
_____
_____Lymphatic conditions (lymphedema, lymphoma, swollen glands, other):_____
_____Neurological conditions (epilepsy, numbness/tingling, sciatica, stroke, other):_____
_____Previous surgeries, please list type and date:_____
_____Recent injury (deep bruise, sprain, whiplash, other): _____
_____Skin condition (acne, rash, skin cancer, other):_____
_____Stress:_____
_____Other:_____
_____ALLERGIES:_____
_____List any medication / herbal products you are currently taking:_____

_____

_____

Name of Health Care Provider:_____Phone:_____

Your signature:_____Date:_____