Screening Questionnaire

LEVIN 道 THERAPEUTICS

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? ______________________________

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

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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:

- ❑ Nonsexual/draping
- ❑ Food, drugs, alcohol
- ❑ Oils/lotions/allergies
- ❑ Sanitation
- ❑ Fees/payment
- ❑ Clothing/shiatsu
- ❑ Confidentiality
- ❑ Cancellation/no-show policy
- ❑ Late arrival policy
- ❑ Work setting
- ❑ Special needs/other______________
  ____
  ____
- ❑ Sent packet on______________

What questions or concerns might you have? ______________________________

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

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Notes ____

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