Tony Shannon, LMT
Client Questionnaire

Personal Information

COVID-19 SYMPTOMS

- [ ] Have you had a fever in the last 24 hours of 100°F or above?
- [ ] Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath?
- [ ] Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms?

BASIC INFORMATION

First Name

Last Name

Date of Birth

MM DD YYYY

Gender

Male Female Not Specified

Occupation

CONTACT INFORMATION

Email

Phone (mobile preferred)

Cell

Address

City

State

Zip

EMERGENCY CONTACT INFORMATION

Contact Name

Phone

Relationship

How did you hear about us?

DOCTOR (OPTIONAL)

Physician Name

Phone

Issues to Address Information

Cause of Injury or Concern

How Long Since First Noticed

Describe your treatment goals

Past Treatment

Existing Conditions Information

Respiratory

- [ ] Asthma
- [ ] Bronchitis
- [ ] Chronic cough
- [ ] Emphysema
- [ ] Shortness of Breath

Cardiovascular

- [ ] Blood Clots
- [ ] Cardiovascular Accident
- [ ] Cerebral-vascular Accident
- [ ] Cold Feet
- [ ] Cold Hands
- [ ] Congestive Heart Failure
- [ ] Heart Attack
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Lymphedema
- [ ] Myocardial Infarction
- [ ] Pacemaker
- [ ] Phlebitis
- [ ] Stroke
- [ ] Thrombosis/Embolism
- [ ] Varicose Veins

Skin

- [ ] Bruise Easily
- [ ] Hypersensitive Reaction
- [ ] Melanoma
- [ ] Skin Conditions
- [ ] Skin Irritations

Head & Neck

- [ ] Ear Problems
- [ ] Headaches
- [ ] Hearing Loss
- [ ] Jaw Pain (TMJD)
- [ ] Migraines
- [ ] Sinus Problems
- [ ] Vision Loss
- [ ] Vision Problems

Infectious Conditions

- [ ] Athlete's Foot
- [ ] Hepatitis
- [ ] Herpes
- [ ] HIV
- [ ] Respiratory Conditions
- [ ] Skin Conditions

Women

- [ ] Gynecological Conditions
- [ ] Pregnancy

Soft Tissue / Joint Dysfunction

- [ ] Ankles (Left)
- [ ] Ankles (Right)
- [ ] Arms(Left)
- [ ] Arms(Right)
- [ ] Feet (Left)
- [ ] Feet (Right)
- [ ] Hands (Left)
- [ ] Hands (Right)
- [ ] Hips (Left)
- [ ] Hips (Right)
- [ ] Knees (Left)
- [ ] Knees (Right)
- [ ] Legs (Left)
- [ ] Legs (Right)
- [ ] Lower Back (Left)
- [ ] Lower Back (Right)
- [ ] Mid Back (Left)
- [ ] Mid Back (Right)
- [ ] Neck (Left)
- [ ] Neck (Right)
- [ ] Shoulders (Left)
- [ ] Shoulders (Right)
- [ ] Upper Back (Left)
- [ ] Upper Back (Right)

Family History

- [ ] Cardiovascular Conditions
- [ ] Respiratory Conditions

Miscellaneous

- [ ] Allergies
- [ ] Anaphylaxis
- [ ] Artificial Joints / Special Equipment
- [ ] Arthritis
- [ ] Cancer
- [ ] Crohn's Disease
- [ ] Digestive Conditions
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Diabetes
- [ ] Gout
- [ ] Hemophilia
- [ ] Insomnia
- [ ] Fibromyalgia
- [ ] Lupus
- [ ] Mental Illness
- [ ] Osteo Arthritis
- [ ] Loss of Sensation
- [ ] Other Diagnosed Diseases
- [ ] Other Medical Conditions
- [ ] Rheumatoid Arthritis
- [ ] Osteoporosis
- [ ] Stress
- [ ] Surgical Pins or Wire
- [ ] Shingles

Allergies and other conditions your provider should be aware of

Neurological

- [ ] Burning
- [ ] Cerebral Palsy
- [ ] Herniated Disc
- [ ] Multiple Sclerosis
- [ ] Numbness
- [ ] Parkinsons
- [ ] Stabbing pain
- [ ] Tingling

Please list any medications or drugs you are currently on

Client Waiver Form

Please take a moment to read and initial the following information:

- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
  If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
  I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
  I affirm that I have notified my therapist of all known medical conditions and injuries.
  I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.
  I understand that massage is entirely therapeutic and non-sexual in nature.
  By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.
  24 hour advance notice is required when cancelling an appointment or full price of the session is required. This amount must be paid prior to your next scheduled appointment.

☐ I have read the statement above and agree to all the policies

Client Signature*

Date*