UAB UNIVERSITY RECREATION
The University of Alabama at Birmingham

Massage Therapy Client Questionnaire

General Information

Name:_____ ***Today's Date:_____***

Email:_____ ***Phone #:_____***

Gender:_____ ***Age:_____*** ***Membership Status:_____***

Emergency Contact:_____ ***Phone #:_____***

Package Purchased: Number of sessions? _____

Massage : _____60 minutes_____

Availability for Massage Sessions

Monday:
- ☐ Morning: _____
- ☐ Afternoon: _____
- ☐ Evening: _____

Tuesday:
- ☐ Morning: _____
- ☐ Afternoon: _____
- ☐ Evening: _____

Wednesday:
- ☐ Morning: _____
- ☐ Afternoon: _____
- ☐ Evening: _____

Thursday:
- ☐ Morning: _____
- ☐ Afternoon: _____
- ☐ Evening: _____

Friday:
- ☐ Morning: _____
- ☐ Afternoon: _____
- ☐ Evening: _____

Saturday:
- ☐ Morning: _____
- ☐ Afternoon: _____
- ☐ Evening: _____

Sunday:
- ☐ Morning: _____
- ☐ Afternoon: _____
- ☐ Evening: _____

Additional Comments:

_____

_____

1) How did you hear about our Massage Therapy Services?

_____

_____

2) Have you ever had Massage Therapy before? Yes_____ No____

3) Do you have difficulty lying on your front, back, or side? Yes_____ No____ If yes, please explain_____

*4) Do you have allergic reactions to oils, lotions, ointments, liniments, or other substances put on your skin? explain*_____

5) Do you wear contact lenses ☐ *dentures* ☐ *a hearing aid* ☐

6) Do you experience stress in your work, family, or other aspects of your life? Yes☐ *No*☐

-How would you describe your stress level? Low☐ *Medium*☐ *High*☐ *Very High*☐

-If high, how do you think your stress has affected your health? Muscle Tension☐ *Anxiety*☐

_____

7) For women: Are you pregnant? Yes ☐ *No* ☐ *If yes, how many months?* _____

8) What is your major complaint, if any that you want to improve?

_____

_____

9) When did you first notice this complaint?

_____

10) What event(s) brought it on?

_____

11) What activities aggravate the condition?

_____

_____

12) What have you done to get relief? _____

_____

13) What are your expectations for this visit?

_____

_____

14) Are you currently under medical supervision? Yes ☐ *No* ☐

15) Are you currently taking any medications? Yes☐ *No* ☐ *If yes, please list:*

_____

_____

16) Have you recently had an injury, surgery, or areas of inflammation? *Yes* ☐ *No* ☐ *If yes, please list:*

_____

_____

17) What is the position you spend most of your day in? Sitting☐ *Standing* ☐ *Moving*☐ *Heavy lifting* ☐

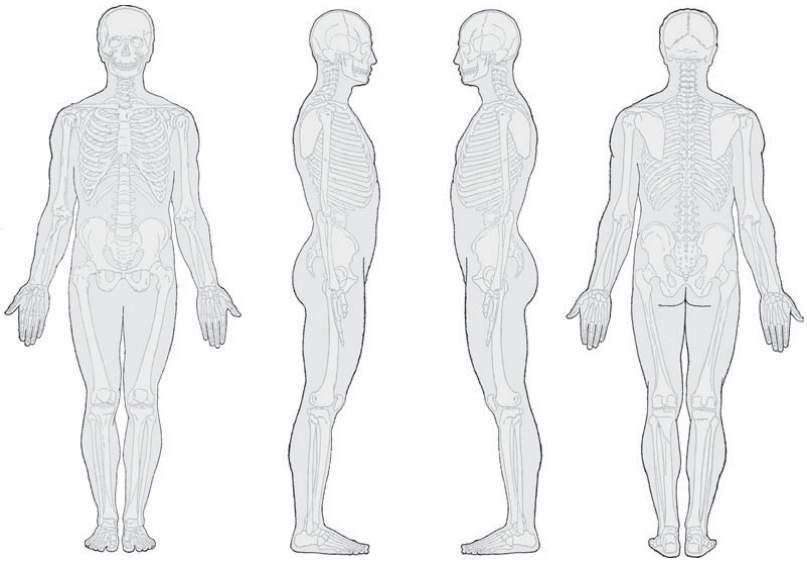
Other _____

MASSAGE THERAPY CLIENT QUESTIONNAIRE

Gender of preferred Massage Therapist:

- ☐ Male
- ☐ Female
- ☐ No preference

Is there a particular area of the body where you are experiencing tension, stiffness, or pain? Yes ◯ No ◯
If yes, please identify below:



All of the above information is correct to the best of my knowledge. I realize that this session is not intended to diagnose or treat any condition that I may have, and is purely for therapeutic purposes. I will not hold the Massage Therapist liable for any exacerbated condition that was not disclosed in the above questionnaire.

Signature: _____ Date:_____ Print Name:_____

Please return this completed form to Membership Services along with payment for your sessions.
Clients will be contacted by URec Staff to schedule your first session within two business days of purchase.

Thank you for including us on your wellness journey!