Massage Questionnaire

Date seen: _____ By: _____ Consult with: _____

Client Information

Preferred Name: _____
Legal Name: _____
Age: _____ Date of Birth: _____
Address: _____
City: _____ Zip: _____
Email: _____
Cell #: _____ Service Provider: _____
Home #: _____ Work #: _____
Best way to contact me would be: ☐ Cell ☐ Home ☐ Work
Opt out of text message reminder: ☐ Yes ☐ No
Occupation/Employer: _____
Emergency Contact: _____
Phone #: _____

Fitness Goals

☐ Weight Loss/Gain ☐ ▼ Body Fat ☐ Improve Diet
☐ ▲ Strength ☐ ▲ Flexibility ☐ Improve Cardiovascular
☐ Other

Exercise History

What have you done in the past?
☐ Yoga ☐ Kettle bell ☐ CrossFit ☐ Pilates ☐ Plyometrics
☐ Functional training ☐ Weights ☐ Cardio ☐ Other
Currently doing? _____
How many days per week? ☐ 0-1 ☐ 2-3 ☐ 2-4 ☐ 3-5 ☐ 6-7
Have you worked with a personal trainer before? ☐ Yes ☐ No

Sleep Quality

How is your sleep? Position? (check all that apply)
☐ Restful ☐ Restless ☐ Hard to sleep
☐ Nightmares ☐ Wake up often
☐ On side ☐ On back ☐ On stomach
What time do you usually go to sleep? _____
Hours of sleep/night? _____

Energy Level

On a scale of 1-10 (10 being highest) what is your energy level during the following times:
AM: _____ Afternoon: _____
Evening: _____ Late PM: _____
After meals: _____ Overall: _____

What services are you interested in?

☐ Massage Therapy ☐ Personal Training ☐ Acupuncture
☐ Physical Therapy ☐ Nutrition Counseling ☐ Chiropractic
☐ Weight Loss Program ☐ Semi-Private Training

How did you hear about us?

☐ Google ☐ Facebook ☐ Instagram ☐ Yelp ☐ Newspaper ☐ Flyer
☐ Other: _____
☐ Family/Friend: _____

Refer a friend for a free consultation

Name: _____ Phone/Email: _____
Name: _____ Phone/Email: _____

Get a $5 credit for each of the following:

☐ Google Review ☐ Yelp Review ☐ Yahoo Review
☐ Like or Check-in on Facebook ☐ Link to our Website
☐ Follow us on Instagram

Daily Habits

For each item listed below, specify if you consume them and how often (i.e. 2 cups/day):
Coffee/Tea: _____ Soda: _____
Alcohol: _____ Water: _____
Fast Food: _____ Tobacco: _____
Vitamins/Minerals: ☐ Multi ☐ Vitamin D ☐ Omega-3

Stress Level

Rate your current stress level on a scale from 1-10 (10 being most stressed). Please note that stress can come in various forms such as being overworked, relationships, health concerns, tiresome family or work responsibilities, excessive fear, worry, anxiety, insomnia, road rage, etc.

Overall Stress: _____
Main Reason for Stress: _____
_____
If your stress level is over 5, what steps are you currently taking to reduce your stress? _____
_____
_____
_____

Surgeries/Hospitalization

What surgeries, operations, traumas, fractures, car accidents, etc. have you had? _____
_____
_____
_____

Medication

Please list any medication you are taking, or have taken in the past, and for how long. State the reason for taking it. _____
_____
_____
_____

Orthopedic Limitations

	Neck	Back	Hip	Knee	Ankle	Shoulder	Wrist
Recent injury	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L
Weak, not chronic	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L
Chronic, not severely limiting	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L
Chronic, severely limiting	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L

Wellness Manager: _____ Plan: _____ Purchased: _____

Consent and Liability Waiver Release Form

I, _____
(parent or guardian if client is under 18) on behalf of

_____
(minor or child under 18)
hereby affirm that I am entering a course of instruction in physical fitness and manual therapy, and the basic safety rules for services connected herewith.

I understand and agree that neither the class nor instructors, practicers, owners, operators, agents, including but not limited to MedxCare Health Professionals and/or affiliates, may be held liable in any way for any occurrence in connection with my physical fitness and performance, conditions and limitations which may result in injury, death, or damages to me or my family, heirs or assignees. I further acknowledge and forever release MedxCare Health Professionals in connection directly or indirectly with my physical fitness, training and manual therapy as a result of MedxCare Health Professionals and/ or any affiliates own negligence, which may result in injury, death or damages to me or my family, heirs or assignees.

In consideration of being allowed to enroll in this service, I hereby personally assume all risks connected with the services, and I further release the instructors, practitioners, program, agents and operators, including but not limited to the persons mentioned, for any injury or damage which may be incurred by me while I enrolled in the fitness or performance service or manual therapy, including all risks connected therewith, whether foreseen or unforeseen; and further claim by me, or my family, estate, heirs, or assignees, arising out of my enrollment and participation in these services.

I further state that I am of lawful age and legally competent to sign the aforementioned release; that I understand that the terms herein are contractual and not merely recital; and that I have signed this document as my own free act.

I have fully informed myself of the contents of the aforementioned and release by reading it before I sign it, I have been advised to submit, at my own expense and time, to a medical examination to ensure myself, and assume my own responsibility of any wellness program, and am physically fit as tested by a medical examination. I also understand that the owner reserves the right of membership. IN WITNESS WHEREOF, I have executed the aforementioned and release and understand there are NO REFUNDS at MedxCare Health Professionals.

Client's Signature:_____

Date: _____

Authorized Signature:_____

Date: _____

We Take Most Insurances

Includes, but isn't limited to; "Anthem Blue Cross PPO, Blue Shield PPO, Aetna PPO, Cigna PPO, United Health Care PPO, Personal Injury cases and Auto Accident Cases, Workmans Compensation cases.

We do not take any HMOs, such as KAISER, ASH (American Specialty Health), Blue Shield HMO, Blue Cross HMO, Aetna HMO etc. We also do not take any government funded insurance programs, such as Medicare, Medi-cal, Medicaid etc.

Insurance Company:

_____

ID#:

_____

Group #:

_____

Primary Holder:

_____

Relation:

_____

I certify that I, and/or my dependant(s), have insurance coverage with

_____

and assign directly to

- ☐ MedxCare H. P.
- ☐ Dr. Walton, D.C.
- ☐ Dr. Eden, D.C.
- ☐ Dr. Rose-Gustafon, LA.c, DTCM
- ☐ Debra Mayah, LAc.
- ☐ Other: _____

all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will last as long as I continue care at MedxCare Health Professionals.

Signature of Patient, Parent or Guardian:

X _____ Date _____

☐ Patient ☐ Mother ☐ Father ☐ Guardian