Practitioner/Clinic Name: ____________________

Contact Information: ________________________

Screening Questionnaire

Client Information

Client Name: ____ Date: ________________

Preferred phone number: ___________________ Best time to call: __________________________

Email address: _____________________________ Preferred form of communication: _______________

Massage Information

How did you hear about me? (referral, Facebook, etc.) ______________________________

Is this a gift certificate? Yes ☐ No ☐

Massage history:

Have you had a massage/bodywork before? Yes ☐ No ☐

Frequency: ______________________________

Types of massage/bodywork received: ______________________________

Preferred types of massage: ______________________________

Reasons for seeking massage? (relaxation, injury, etc.)

____

Description of injury/health condition:

____

Possible complications/medications:

____

Expected outcomes (functional improvement, symptom relief, wellness):

____

Typical activities of daily living (affected by condition?):

____

Occupation (affected by condition?):

____

Are you seeking insurance reimbursement? Yes ☐ No ☐

Car collision/personal injury? ______________________________

On-the-job injury? ______________________________

Private health insurance? ______________________________

Do you have a physician referral with diagnosis codes? ______________________________

Let clients know if you provide billing services, and if so, for what types of claims, or if you will simply provide receipts and/or copies of records for them to submit for reimbursement. Let clients know a physician referral demonstrating medical necessity is required for insurance reimbursement/health savings account reimbursement regardless of who submits bills.

Best times for massage: ______________________________

Practitioner/Clinic Name: ____________________

Contact Information: ________________________

Screening Questionnaire

Communication Checklist

☐ Fees/forms of payment
☐ Late arrival policy
☐ Parking/directions
☐ Clothing/shiatsu
☐ Food/drugs/alcohol
☐ Cancellation/No-show policy
☐ Confidentiality
☐ Work setting
☐ Modesty/Nonsexual/draping
☐ Oils/lotions/allergies

COVID-19 Related Questions

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐
2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes ☐ No ☐
3. Do you now, or have you recently had, any chills, muscle aches, new loss of taste or smell, or new rashes or lesions? Yes ☐ No ☐
4. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ☐ No ☐

Inform clients of any new protocols you've implemented as a result of COVID-19, including directions about arrival, wearing a mask during the session, and getting set up for contactless payment beforehand.

Do you have special needs I should prepare for:

____

Do you have any questions or concerns:

____

If out-call, ask for directions, parking, or special instructions:

____

Packet Checklist

☐ Health Information
☐ Health Status Report
☐ Billing Information
☐ Directions/map

Date sent ________

Additional Notes

____

____

____

____

MEMBER
Associated Bodywork & Massage Professionals