NEW CLIENT QUESTIONNAIRE

Sandra Norris Wheeler
LMT, CST, Lic #1610

EMAIL: _____

NAME: _____ DATE: _____

MAILING ADDRESS: _____

TELEPHONE: (____)_____ home (____)_____ work DOB: _____/____/_____

OCCUPATION: _____

CURRENT ACTIVITY / EXERCISE LEVEL: ❑ low ❑ medium ❑ high

Preferred activity/ form of exercise: _____

Do you have any primary complaint or areas of pain for which you are seeking treatment?

❑ yes ❑ no If yes, please describe: _____

_____

_____

Because of this problem I now have difficulty with: _____

_____

Have you received previous treatment for this condition? ❑ yes ❑ no

If yes, what type of treatment? _____

Has this treatment been helpful? _____

Client History: If yes to any of the below, please explain briefly here or on the reverse side.

❑ yes ❑ no Are you presently under a physician or other health professional's care?

❑ yes ❑ no Are you presently taking medication? Are you seeking a therapist or counselor?

Medications _____

Therapist or counselor _____

Have you ever had:

❑ yes ❑ no arthritis
❑ yes ❑ no cancer
❑ yes ❑ no high blood pressure
❑ yes ❑ no fractures, torn cartilage or ligaments
❑ yes ❑ no dislocated joints
❑ yes ❑ no surgery
❑ yes ❑ no back problems / spinal or nerve injuries
❑ yes ❑ no contagious skin diseases / lesions
❑ yes ❑ no orthodontic / braces Approx. age: _____

please turn over

(541) 912-9556 • sandra@sandranwheeler.com
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Are you aware of any past injuries or illnesses that affect your personal health? ❑ yes ❑ no

If yes, please specify: _____

_____

Name and address of primary care physician: _____

_____

If you are currently pregnant, what is your approximate due date?_____

Name of physician / midwife / etc.: _____

Number of pregnancies: _____ Number of children: _____

How are / were your pregnancies and childbirth experiences? _____

_____

Client Goals: What would you like to do as a successful result of therapy? _____

_____

_____

Have you had any previous professional massage or other bodywork? ❑ yes ❑ no

If yes, what type of work? _____

_____

Name of practitioner(s): _____

_____

How did you hear about me? ❑ referral: _____ ❑ a friend: _____

❑ seminar: _____ ❑ other: _____

If there is any other information that you would like to convey to me so that I may better assist you, please do not hesitate to let me know either now or during our sessions together.

Thank you for filling this out. All information is strictly confidential.

GIFT CERTIFICATES ARE ALWAYS AVAILABLE

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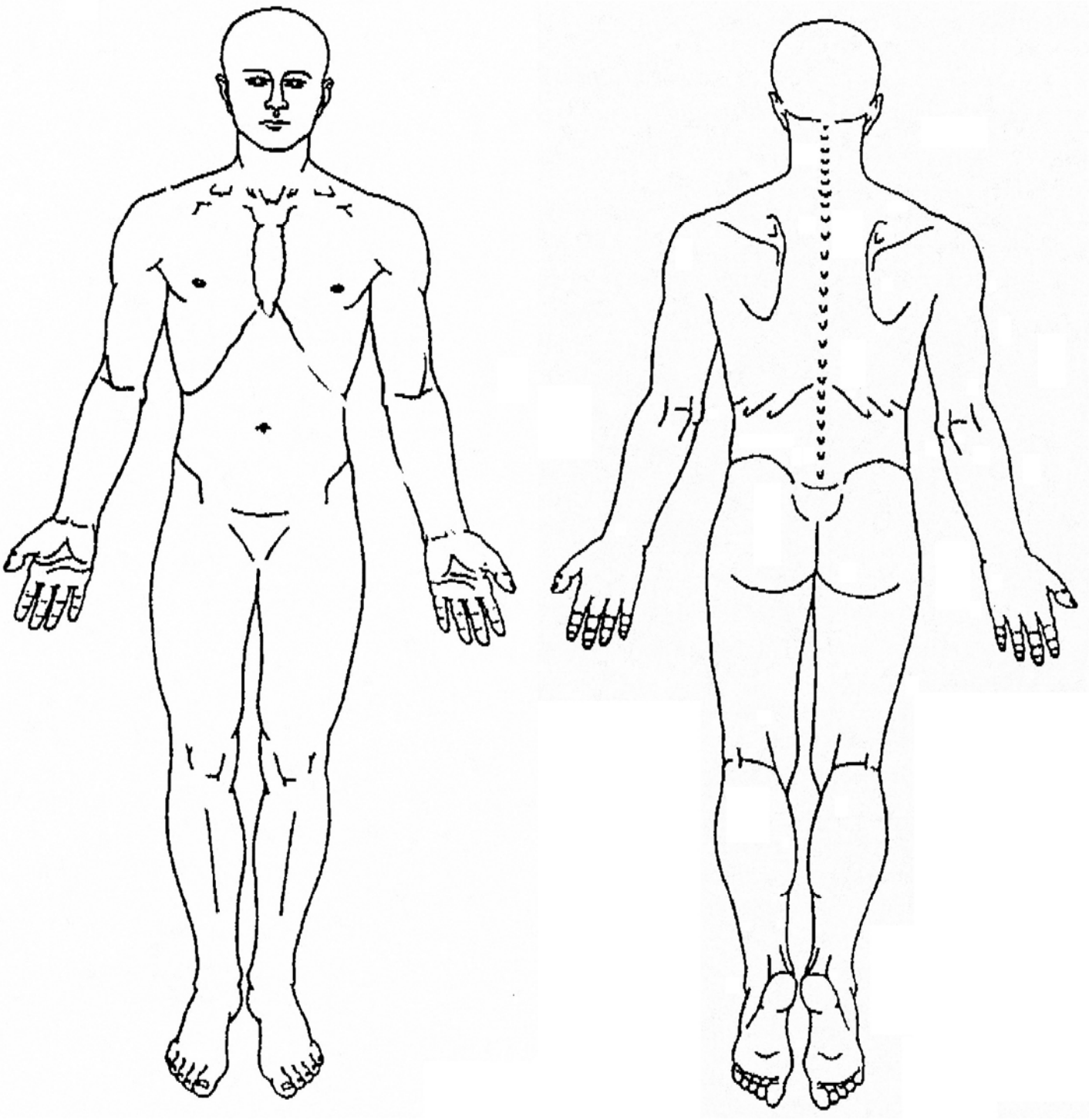
VISUAL ASSESSMENT

- **Please indicate areas of soreness or pain with a "P"**
- **Please indicate areas of operations or scarring with an "S"**
- **Lightly shade in any other affected areas and specify involvement (numbness, heat, etc.)**



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