Practitioner/Clinic Name:	_ Screening Questionnaire	
Contact Information:	(page 1 of 2)	
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 relie	f, 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?		
copies of records for them to submit for reimbursement. Let	what types of claims, or if you will simply provide receipts and/or clients know a physician referral demonstrating medical vings account reimbursement regardless of who submits bills.	
Best times for massage:		



Practitioner/Clinic Name:		Screening Questionnaire		
Contact Information:		(page 2 of 2)		
Communication Checklist  Fees/forms of payment	☐ Cancellation/No-show polic	v.		
☐ Late arrival policy ☐ Confidentiality		у		
☐ Parking/directions ☐ Work setting				
☐ Clothing/shiatsu ☐ Modesty/Nonsexual/draping		2		
☐ Food/drugs/alcohol				
COVID-19 Related Questio	ns			
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 □				
<ol> <li>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 □</li> </ol>				
Do you have special needs I sh	ould 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				

