Welcome to Kaiser Massage Therapy!

Please take a few moments to fill out this questionnaire. This will help us serve you better.

Name____ Date ________________

Address_______________________City_______________State____Zip_____

Home Phone________________Work_______________Cell______________

Type of Employment______________________________D.O.B_____________

Email____

1. How did you hear about our office? ______________________________
2. Have you ever had a massage before? Yes or No   Did it help? Yes or No
3. Are you presently being seen by a Doctor? Yes or No
4. Do you have any of the symptoms or conditions listed below? (please circle)

Neck Pain	Shoulder Pain	Allergies	Pregnant
Low Back Pain	Sciatica	Ankle Pain	Mid-back Pain
Numbness	Headaches	Blurred Vision	Nausea
Knee Pain	Hip Pain	Ankle/Foot Pain	Heart Problems

5. Have you been involved in a motor vehicle accident? Yes or No
6. Have you been involved in or are you being treated for a work injury? Yes or No
7. Have you had any slip and fall or personal injury claims within a year? Yes or No
8. Is there anyone that you would like us to contact for a similar massage? Yes or No
9. Are you interested in the Kaiser Therapy Monthly Program? Yes or No

Gratuity is not included in our massage prices. It is not required, but always appreciated.