

Practitioner/Clinic Name: De Premier Spa
Contact Information 281-496-3772

Medical Massage Therapy Screening Questionnaire

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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?

Note: We do not provide insurance billing services. We simply provide receipts and/or copies of records to submit for reimbursement. Clients must come with physician referral note demonstrating medical necessity is required for insurance reimbursement/health savings account reimbursement.

Best times for massage:

Practitioner/Clinic Name:

Screening Questionnaire

Contact Information

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Communication Checklist

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

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