MASSAGE THERAPY QUESTIONNAIRE

Name: _____ Date: _____

Have you experienced a professional massage before? ☐ YES NO ☐

What is your preferred pressure? LIGHT ☐ FIRM ☐ DEEP ☐

Are you comfortable receiving treatment on: **(circle all that apply)**

☐ Gluteal region ☐ pectoral muscles ☐ scalp ☐ face ☐ abdomen ☐ feet

For Gluteal Region, are you more comfortable with being touched: (circle what applies)

Over the sheet ☐ Under the sheet ☐

Describe your main concerns and reasons for visit (relaxation/pain relief).

_____

_____

What qualities do you seek in a Massage Therapist?

_____

_____

Do you experience stress/tension from work, sports, or hobbies requiring repetitive movements? Briefly describe:

_____

_____

Previous Treatment for Your Current Symptoms:

_____

_____

Goals for treatment (What do you expect to get from treatment?):

_____

_____