CLIENT FEEDBACK

Date: _____ Treatment Length & Type:_____

Was the room setting pleasing? Y or N If not, explain:_____

_____

Were you able to relax? Y or N If not explain: _____

_____

Was there anything that you DID or DIDN'T like about the massage or the therapist?

_____

_____

Other comments: _____

_____

Printed Name: _____ Signed: _____
(Optional) (sign to authorize use of comments for publication)

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