
# Client Feedback Information

Client's Name: _____ Therapist's Name: Keith Gosline, LMT

Date: _____ Time of your appointment: _____

Length of Treatment ( ) ½ hr ( ) 1 hour ( ) 1 ½ hours ( ) 2 hours

Clients Age ( )Under 20 ( )21-30 ( )31-40 ( )41-50 ( )51-60 ( )Over 60

Did your treatment last the length of time you expected? ( )Yes ( )No if no, please explain

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How did you feel before your treatment?_____

How did you feel after your treatment?_____

Did I fully describe what I planned to do?_____

Was the room setting (music, lighting, décor) pleasing?_____

Were you comfortable and able to relax during the treatment?_____

During treatment, how was the pressure? ( )too light ( )just enough ( )too much

Weak points (anything that I could have been done differently)?_____

_____

Strong points?_____

Is there anything I could improve on?_____

How did you hear about me ?

_____

May I contact you for follow up, or future promotions? ( )Yes ( )No