



1921-C North Pointe Drive/Durham/NC/27705/919477-9887

Client Health History

Therapist: _____

Today's Date: _____

Personal Information:

Name: _____ Email: _____

Address: _____ Home#: _____

City, State, Zip: _____ Work#: _____

Date of Birth: _____ Age: _____ Cell# _____

Referred By: _____ Occupation: _____

Emergency Contact Name and Phone #: _____

Do we have permission to contact you via mail, email or phone? Y/N

Preferred method of contact (please circle): Home Work Cell Email

Objective for Session:

Have you ever received professional massage or other types of bodywork before? If yes, what type and when?

Reason for visit today: _____

Current Conditions:

Primary areas of complaint: _____

How did this condition develop and when did it begin? _____

What makes it worse? _____

What makes it better? _____

Describe your daily physical activities at home and at work: _____

Please rate your stress level on a scale from 1 to 10 (10 being the most stressed): _____

Please rate your general health level on a scale for 1 to 5 (1 being excellent health): _____

Health History:

Please circle any conditions that apply to you:

Muscle- Skeletal:

Bone or Joint Disease
Joint stiffness / swelling
Broken / fractured bones
Arthritis
Sprains/Strains
Low Back/Hip/Leg Pain
Neck/Shoulder/Arm Pain

Muscle-Skeletal cont.

Lupus
Jaw Pain/TMJ
Osteoporosis
Scoliosis
Spasms/Cramps
Headaches/Head Injuries
Other _____

Circulatory/Respiratory

Heart Conditions
Varicose veins
Blood Clots
High/Low Blood Pressure
Lymphodema
Breathing Difficulty
Stroke

Reproductive:

Pregnancy _____ weeks
PMS
Breast implants (within 6 months)
Endometriosis _____

Digestive:

Diverticulitis
Irritable Bowel Syndrome (IBS)
Crohn's Disease
Constipation

Other:

Depression
Diabetes
Cold/Flu
Fibromyalgia

Allergies _____
Asthma
Hernia
Past Physical/ Emotional Abuse

Please list any medications you take regularly _____

Please list any surgeries _____

I have listed all my known medical conditions and physical limitations, and I will inform my massage therapist of any changes in my physical health. I agree to communicate with my therapist any time I feel like my well-being is being compromised.

I understand and agree: 1) the massage therapy that I am given is for the purpose of stress reduction, relief from muscular tension/ spasm, and/ or for improving circulation; 2) a therapist neither diagnoses illness, disease, or any other medical, physical, or mental disorder, nor performs any spinal manipulations; 3) I am responsible for consulting a qualified physician for any ailments that I may have.

All sessions are non-sexual. I understand that if I should make advances toward the therapist or have sexual intentions relating to the session, the therapist has the right to terminate the massage.

I understand that all services rendered are my personal responsibility and payment is due at the time of service unless prior arrangements have been made. Please note that a 24 hour cancellation is required or a fee will be charged.

Signature: _____ Date: _____