4206 N. Roxboro St., Suite 130/Durham/NC/27704/919-294-8808

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: _______________________________________

____

Health History:
Please circle any conditions that apply to you:

Muscle-Skeletal	Muscle-Skeletal cont.	Circulatory/Respiratory
Bone or Joint Disease	Lupus	Heart Conditions
Joint Stiffness/Swelling	Jaw Pain/TMJ	Varicose Veins
Broken/fractured bones	Osteoporosis	Blood Clots
Arthritis	Scoliosis	High/Low Blood Pressure
Sprains/Strains	Spasms/Cramps	Lymphedema
Low Back/Hip/Leg Pain	Headaches/Head Injuries	Breathing Difficulty
Neck/Shoulder/Arm Pain	Other ____________________	Stroke

Reproductive	Digestive
Pregnancy ______ weeks	Diverticulitus
PMS	Irritable Bowel Syndrome (IBS)
Breast implants (within 6 months)	Crohn's Disease
Endometriosis ____________	Constipation

Other:		
Depression	Allergies _________________	Cancer
Diabetes	Asthma	
Cold/Flu	Hernia	
Fibromyalgia	Past Physical/Emotional Abuse	

Dermatological:	
Acne	Melasma (Pregnancy Mask)
Rosacea	Hyperpigmentation
Eczema	Dullness
Sensitivity	Enlarged Pores
Redness	Wrinkles
Fine Lines	Loss of firmness

Please list any medications you take regularly: ____
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____

Please list any surgeries: ____
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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 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.

I understand and agree: 1) Skin care recommendations are customized recommendations from Dr. Katie Rodan and Dr. Kathy Fields.

Signature: ______________________________________ Date: ____________________