North Carolina Baptist Hospital
Massage Therapy Department

Massage Therapy
Health History Form

Name _____ **Age** _____
Address _____ **Weight** _____
City _____ **State** _____ **Zip** _____
Home Phone _____ **Work Phone** _____
Occupation _____ **Referred By** _____
E-Mail _____
In case of emergency contact : _____

Do you currently have problems with:

- ☐ Bladder
- ☐ Circulation
- ☐ Constipation
- ☐ Diarrhea
- ☐ Digestion
- ☐ Fatigue
- ☐ Insomnia
- ☐ Kidneys
- ☐ Low Back
- ☐ Migraines
- ☐ Neck
- ☐ Respiration
- ☐ Shoulder
- ☐ Sinuses
- ☐ Sinus Headache
- ☐ Spine
- ☐ Stomach
- ☐ Tension
- ☐ Tension Headache
- ☐ _____

Have you been diagnosed with:

- ☐ Aneurysm
- ☐ Arthritis
- ☐ Arrhythmia
- ☐ Cancer _____
- ☐ Chronic Fatigue
- ☐ Pregnant _____ Weeks
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Gallbladder Problems
- ☐ Heart Problems
- ☐ Herpes
- ☐ Postpartum _____ Weeks
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Hypoglycemia
- ☐ Low Blood Pressure
- ☐ Varicose Veins
- ☐ DVT's

Operations: _____ Date: _____
Injuries: _____ Date: _____
_____ Date: _____
Medications: _____ _____ _____
_____ _____ _____
Site Restrictions: _____

Are there any areas of sensitivity or areas that you would not like touched?
☐ Yes ☐ No If yes, please specify _____

Are you allergic to any oils or fragrances?
☐ Yes ☐ No If yes, please specify _____

Have you had a professional massage before?
☐ Yes ☐ No If yes, please specify _____
What did you like best about your last massage? _____
What did you like least about your last massage? _____
What kind of hands-on pressure are you comfortable (i.e. light, medium, deep)? _____

Do you have any contagious skin conditions or open wounds on your body?

☐ Yes ☐ No If yes, please specify _____

(Herpes, Poison Ivy, Shingles, etc.)

Do you have any positioning restrictions:

☐ Can lay face down or face up no problems
☐ Can lay face up only
☐ Can lay on side only R or L, either
☐ Do not massage _____

Current stress reduction and exercise activities:

☐ Aerobics ☐ Bike ☐ Hike
☐ Lift Weights ☐ Meditate ☐ Pilates
☐ Run ☐ Swim ☐ Walk
☐ Yoga ☐ Other _____

What body areas should have priority during your session?

☐ Abdominals ☐ Arms
☐ Back ☐ Face
☐ Feet ☐ Legs
☐ Neck ☐ Shoulders

What are you trying to achieve during today's massage section?

☐ Relaxation ☐ Pain Relief ☐ Both

I understand that Massage Therapy involves hands-on application of pressure to relieve muscle tension. Because a Massage Therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to inform the Massage Therapist and keep therapist updated on my physical health. I have no condition that would contraindicate this and the practitioner has my permission to apply massage therapy techniques.

I understand that if I arrive late to an appointment the Massage Therapist will give me the remainder of my session time and I will be billed for the full amount of the scheduled massage. Canceling or rescheduling an appointment less than 24 hours before the scheduled appointment time will result in a charge of the full amount of the scheduled massage. The amount may be paid in full at my next scheduled appointment time or I will be billed with payment due within 14 days of the missed appointment date.

I have read and understand the above statements and the information documented above is current and accurate.

_____ _____

Signature **Date**

_____ _____

Parental Signature **Date**

(If client is under 18 years of age)

Comments:

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LMBT

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