

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:

- | | | | |
|---------------------------------------|------------------------------------|---|---|
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Neck | <input type="checkbox"/> Spine |
| <input type="checkbox"/> Circulation | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Respiration | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Low Back | <input type="checkbox"/> Sinuses | <input type="checkbox"/> Tension Headache |
| <input type="checkbox"/> Digestion | <input type="checkbox"/> Migraines | <input type="checkbox"/> Sinus Headache | |

Have you been diagnosed with:

- | | | |
|---|---|--|
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Herpes | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Pregnant _____ Weeks | <input type="checkbox"/> Postpartum _____ Weeks | <input type="checkbox"/> 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 on side only R or L, either
 Can lay face up only Do not massage _____

Current stress reduction and exercise activities:

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

What body areas should have priority during your session?

Abdominals Back Feet Neck
 Arms Face Legs 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:

LMBT

