Client Health History
Confidential Information
(Please print clearly)

Name _____ Date _____

Address _____ Day # _____

City/Zip _____ Evening # _____

Date of Birth _____ Age _____ Gender _____

Occupation _____ Referred By _____

Have you ever received massage therapy? □ Yes □ No
If Yes, when was the date of your last session? _____

What type of massage have you received? □ Deep Tissue □ Swedish
□ Sports Related □ Other

Are you currently taking any medications? □ Yes □ No
If Yes, please list the medications. _____
_____
_____

Are you currently under the care of a physician? □ Yes □ No
If Yes, please describe. _____
_____
_____

Are you currently pregnant? □ Yes □ No If Yes, when is your due date? _____

Do you have a history of, or currently have, any of the following conditions?
(Please check all that apply)

Circulatory
□ Blood Clots
□ Heart Condition
□ High/Low Blood Pressure
□ Phlebitis/Varicose Veins
□ Other:_____

Digestive
□ Gas/Bloating
□ Irritable Bowel Syndrome
□ Ulcers
□ Other:_____

Musculoskeletal
□ Arthritis/Gout
□ Bursitis/Tendonitis
□ Headaches
□ Low Back Pain
□ Mid Back Pain
□ Neck/Shoulder Pain
□ Osteoarthritis/Rheumatoid Arthritis
□ Osteoporosis
□ Other:_____

Nervous System
□ Seizure Disorder
□ Spinal Cord Injury
□ Stroke
□ Other:_____

Respiratory
□ Allergies
□ Asthma/Breathing Trouble
□ Emphysema
□ Sinus Problems
□ Other:_____

Skin
□ Allergies
□ Athletes Foot
□ Rashes
□ Other:_____

Other
□ Anxiety/Stress
□ Cancer
□ Chronic Fatigue
□ Diabetes
□ Edema
□ Other:_____

Are you currently experiencing any of the following conditions?

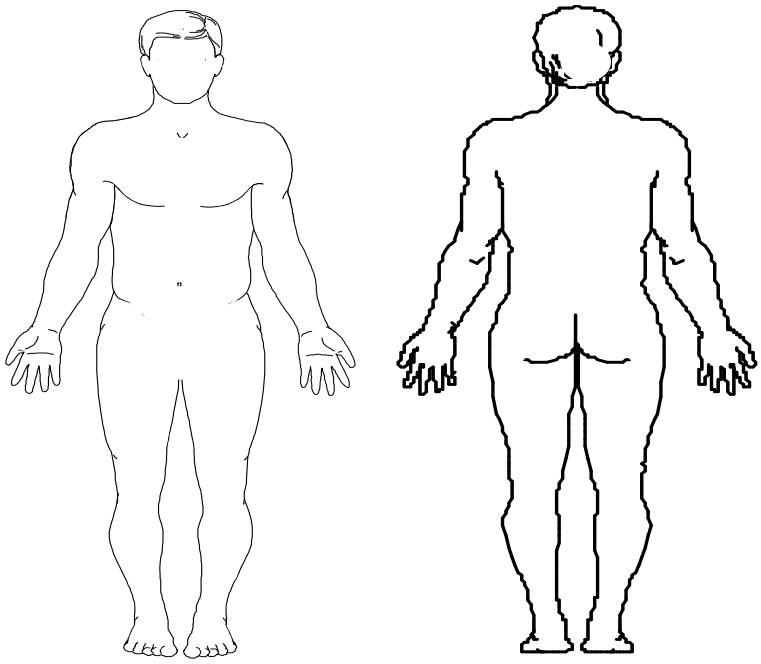
☐ Cold/Flu ☐ Infection ☐ Open cuts, bruises or burns

☐ Fever ☐ Inflammation ☐ Sunburn

☐ Severe Pain – Please describe: _____

_____

Please indicate areas where you are experiencing pain on the drawing below:



I certify that all the answers and statements listed in the Client Health History are my own and true to the best of my knowledge.

_____ _____

Signature Date Witness Date

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UNC HEALTH CARE