Healing Touch Charlotte, Inc. David W. Turner NCTMB, LMBT - NC Lic. #900

Client Information

Name ______________________

Address ______________________

City __________ State ______ ZIP ______

Phone Numbers: Home (______) __________

Work (______) __________

Email Address ______________________

Primary Physician ______________________

Date of Birth ______________________

Referred by ______________________

Date of initial visit ______________________

Emergency Contact Person

Name ______________________

Phone ______________________

How did you hear about us?

❑ Family / Friend ❑ Website ❑ Internet - Search Engine: __________ ❑ Other: __________

Massage Experience

Is this your first visit to a professional massage therapist? __________

If you have been to a professional massage therapist before:

How often do you get a massage? __________ What pressure do you prefer? __________

What are your expectations of this visit? ______________________

Health History

Check the body movements that you perform regularly:

❑ Sitting ❑ Stooping ❑ Lifting ❑ Other: __________
❑ Standing ❑ Bending ❑ Driving

Which movements cause pain? ______________________

What is your occupation? ______________________

What sports or regular exercises do you regularly participate in? ______________________

Have you ever had surgery? ______ Explain: ______________________

Have you ever been hospitalized? ______ Explain: ______________________

Are you receiving any other type of medical treatment? ______ Explain: ______________________

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Are you pregnant? ______ If so, how many weeks / months? ______________________

Are you currently taking any medications? ______

If yes, please list medications and what they are for: ______________________

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Health History Information — page 2

Please check any conditions that you currently experience, or that you have experienced in the last five years:

Musculoskeletal
- ❑ Fibromyalgia
- ❑ Spasms/Cramps
- ❑ Sprains/Strains
- ❑ Osteoporosis
- ❑ Postural Deviations
- ❑ Gout
- ❑ Osteoarthritis/Rheumatoid Arthritis
- ❑ TMJ
- ❑ Cysts
- ❑ Bursitis
- ❑ Plantar Fascitis
- ❑ Tendonitis
- ❑ Torticollis
- ❑ Whiplash Syndrome
- ❑ Carpal Tunnel Syndrome
- ❑ Sciatica
- ❑ Thoracic Outlet Syndrome
- ❑ Headache
- ❑ Leg Pain
- ❑ Arm Pain/Shoulder Pain
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Hip Pain
- ❑ Other ______________

Circulatory
- ❑ Anemia
- ❑ Hemophilia
- ❑ Hypertension
- ❑ Low Blood Pressure
- ❑ Raynaud's Disease
- ❑ Varicose Veins
- ❑ Heart Condition
- ❑ Blood Clots/Phlebitis
- ❑ Diabetes
- ❑ Other ___________

Digestive
- ❑ Ulcers
- ❑ Irritable Bowel Syndrome
- ❑ Colitis
- ❑ Gallstones
- ❑ Hepatitis
- ❑ Crohn's Disease
- ❑ Diarrhea
- ❑ Gas/Bloating
- ❑ Indigestion
- ❑ Other _________

Nervous System
- ❑ ALS
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Bell's Palsy
- ❑ Neuritis
- ❑ Spinal Cord Injury
- ❑ Stroke
- ❑ Trigeminal Neuralgia
- ❑ Seizure Disorders
- ❑ Numbness/Tingling/Twitching
- ❑ Other __________

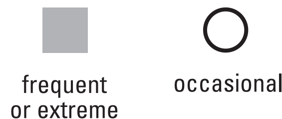
Respiratory
- ❑ Pneumonia
- ❑ Sinusitis
- ❑ Asthma
- ❑ Trouble Breathing
- ❑ Dizziness
- ❑ Other______________

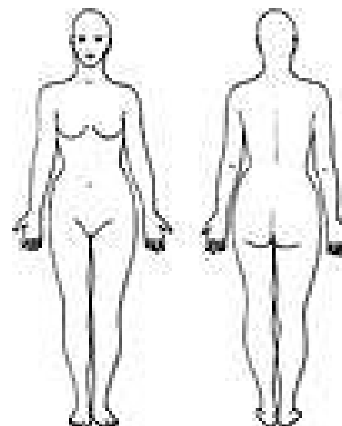
Skin
- ❑ Fungal Infections
- ❑ Acne
- ❑ Impetigo
- ❑ Dermatitis/Eczema
- ❑ Psoriasis
- ❑ Open Wound or Sore
- ❑ Rashes
- ❑ Warts/Moles
- ❑ Athletes Foot
- ❑ Other _________

Other
- ❑ Insomnia
- ❑ Anxiety/Panic Attacks
- ❑ PMS
- ❑ Grief Process
- ❑ Cancer
- ❑ Substance Abuse
- ❑ Pregnancy
- ❑ Chronic Fatigue
- ❑ HIV/AIDS
- ❑ Lupus
- ❑ Kidney Disease
- ❑ Bladder Infection
- ❑ Postoperative Situation
- ❑ Edema
- ❑ Other ___________

Where do you feel pain, soreness or discomfort?

Please ***shade*** in anywhere you feel frequent muscle or joint pain and stiffness, and ***circle*** the areas where you feel pain occasionally:





The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health.

Signature: ____ Date: ____________