Healing Touch Charlotte, Inc.

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Client Information

Name _____ Date of Birth _____

Address _____ Referred by _____

City _____ State _____ ZIP _____ Date of initial visit _____

Phone Numbers: Home (_____) _____

Work (_____) _____ Emergency Contact Person

Email Address _____ Name _____

Primary Physician _____ 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 ☐ Standing ☐ Stooping ☐ Bending ☐ Lifting ☐ Driving ☐ Other: _____

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: _____

_____

Are you currently taking any medications? _____

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

_____

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_____

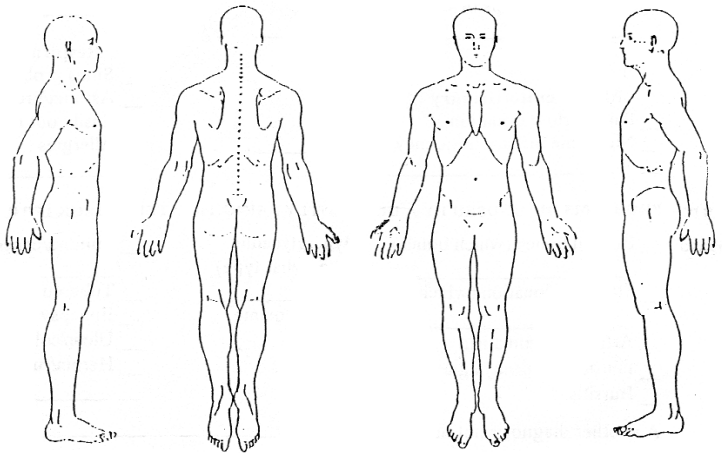
Skin
- ☐ Fungal Infections
- ☐ Acne
- ☐ Impetigo
- ☐ Dermatitis/Eczema
- ☐ Psoriasis
- ☐ Open Wound or Sore
- ☐ Rashes
- ☐ Warts/Moles
- ☐ Athletes Foot
- ☐ Other _____

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:

frequent or extreme — occasional



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: _____