



# Charleston Massage and Flexibility Ctr

"Feel The Difference"



## Client Health History Form

In order to maximize the effectiveness and safety of your massage, please take the time to fill out this questionnaire. This information will be treated confidentially so please answer as completely as possible. Your feed back is appreciated during and at the end of the session to help in tailoring the massage to serve in the best possible way.

### Personal Data

Name: \_\_\_\_\_ Date of Initial Visit: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone:(Cell) \_\_\_\_\_ (Work) \_\_\_\_\_ (Home) \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

### Massage History/Treatment Information

Previous Massage? \_\_\_\_ If so where? \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

What is your goal/purpose of today's visit? (relaxation, pain relief, etc):  
\_\_\_\_\_  
\_\_\_\_\_

Is there any area that is particularly bothering you or you would like more time spent on?  
\_\_\_\_\_  
\_\_\_\_\_

Are you under the care of a Physician/Health Care Practitioner? \_\_\_\_ If so, for what? \_\_\_\_\_

\_\_\_\_\_ Do we have permission to contact your Physician/Health Care

Practitioner? \_\_\_\_ Physician's/Practitioner's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Are you taking any medications(oral/topical),vitamins, or other supplements? \_\_\_\_ If so, for what? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you exercise on a regular basis? \_\_\_\_ Type/Frequency: \_\_\_\_\_  
\_\_\_\_\_

### Health History

Do you have trouble lying on any part of your body? \_\_\_\_\_

Habits: Consume alcohol? \_\_\_\_\_ Use tobacco products? \_\_\_\_\_

Consume caffeine? \_\_\_\_\_ Problems sleeping? \_\_\_\_\_

Are you pregnant? \_\_\_\_ If so, how far along? \_\_\_\_\_

Please check any that apply:

\_\_\_ Heart condition/Pacemaker

\_\_\_ High Blood Pressure/Varicose veins

\_\_\_ Fever Blisters

\_\_\_ Breathing difficulties

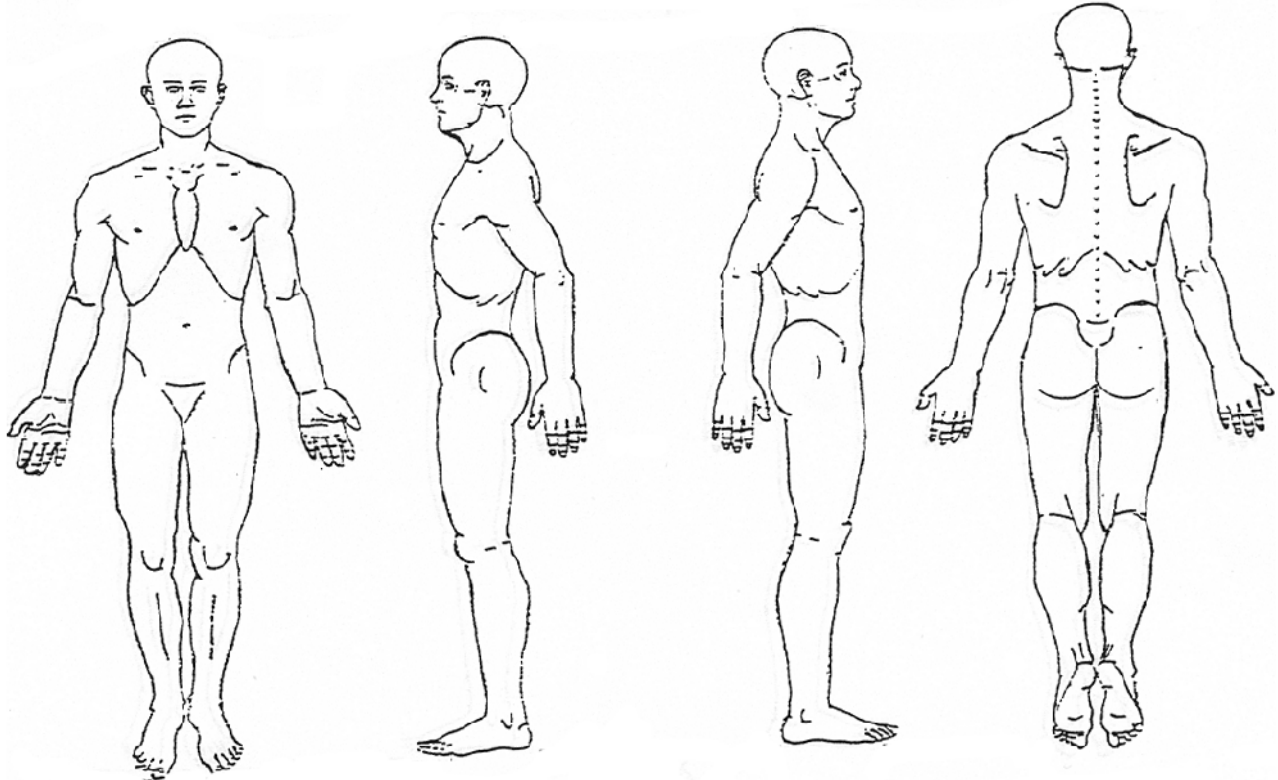
\_\_\_ Diabetes

\_\_\_ Cancer/Tumors

(OVER)

- Painful menstruation/Hysterectomy
- Skin diseases/sensitivity
- Herniated disc
- Seizure disorders
- Headaches
- Allergies/Sinus Problems
- Arthritis/Metal plates/pins
- STD/HIV

**Circle Any Areas That Are Causing You Any Discomfort**



It is my choice to receive massage therapy. I realize that the treatment is being given for the well being of my body and mind. I have completed this form to the best of my knowledge and accept any consequences that may result from any undisclosed information. I understand that massage therapy is a health aid and is in no way to take the place of physician's care when necessary. I understand that this is a professional massage and any inappropriate actions on my part will result in the immediate termination of the session at full compensation. Information exchanged during a session is educational in nature and is intended to help me become more familiar with my own health status and is to be used at my own discretion.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapy Session Dates:

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____