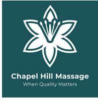


Chapel Hill Massage

Client Information and Health Questionaire

In order to maximize the effectiveness and safety of your massage sessions with your therapist, please take the time to carefully complete this form. This information will be treated confidentially.

Name_______________________________________ Date ____

Address_____________________________________ Height ____

City _______________________________________ D.O.B. ____________/___________/_________________

State ______________ Zip ____________________ Occupation ____

Best way to contact ___________________________ Email Address ______________________________________

Preferred Phone (_______)____________________ Home Work Cell

Emergency Contact ____________________________ Phone (____) ______________________________________

Relationship _________________________________ Do you have a Health Care Power of Attorney? □ Yes □ No

Please check the following conditions that apply or have applied to you:

□ Abdominal Hernia	□ Diarrhea	□ Neck Pain
□ Arthritis	□ Digestive Problems	□ Numbness: Feet/Hands
□ Asthma	□ Ears Ringing	□ Osteoporosis
□ Back Pain	□ Edema	□ Phlebitis
□ Blood Clots	□ Fainting Spells	□ Respiratory Problems
□ Broken Bones	□ Headaches	□ Severe Depression
□ Bursitis	□ Heart Condition	□ Severe Irritability
□ Cancer	□ Hemophilia	□ Shortness of Breath
□ Chest Pain	□ Herniated Disc or Disc Disease	□ Sinusitis
□ Circulatory Problems	□ High Blood Pressure	□ Skin Disorders
□ Cold Feet/Hands	□ Infectious Diseases	□ Stomach Disorders
□ Constipation	□ Loss of Balance	□ Urinary Tract Infections
□ Convulsions	□ Low Blood Pressure	□ Varicose Veins
□ Covid-19 Long-Haul	□ Menstrual Pain/PMS	□ Other ____________________
□ Diabetes	□ Muscle/Joint Pain	□ Other ____________________

Descriptions: ____

____

____

Are you pregnant? □ Yes □ No If yes, how far along? ____

Do you wear/have: □ Contact Lenses □ Dentures/Removeable Bridgework □ Prostetics □ Pace Maker or ICD

Are you under care of a medical doctor, chiropractor or therapist? □ Yes □ No

If yes, for what? ____

____

Are you currently taking any medication? □ Yes □ No Any medications taken in the past 6 months? □ Yes □ No

If yes, what? ____

____

Primary Care Physician: ____Phone: ____

Please describe, including dates any recent or past injuries, accidents, surgeries and treatments received: _________________________

____

____

Please indicate any allergies and reactions: ____

____

Have you had Covid-19? If so, when and do you have any long term effects? ____

____

Have you had the Covid-19 vaccine? If so, when? ____

Referred by: ____ Have you had a professional massage before? □ Yes □ No

What are your goals/concerns for today's session? : □ Stress □ Pain □ Self-help □ Relaxation □ Other ______________

____

How would you describe your health? ____

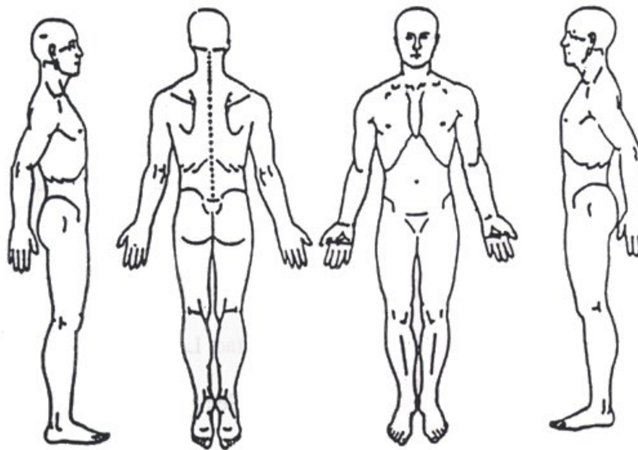
____

Do you experience difficulty lying on your □ Front □ Back □ Side?

Preferred Pressure of Massage: □ Gentle/Light □ Medium □ Deep

Preferred Music? ____

Please indicate location(s) of sore/painful areas or specific areas you want massage work on the diagram below:



The following may sometimes occur during massage. They are normal responses to relaxation and/or touch, and you need not be embarrassed nor feel you should suppress them. Movement or release of intestinal gas - crying - laughing - strong emotions - sighing - groaning - yawning - softening of muscle tissue - cognitive or felt memories - stomach gurgling - need to move or change position.

At any time during your session please let me know if there is anything I can do to help you feel more comfortable.

Financial Policy: We ask our clients to pay at the end of each visit, unless prior arrangements have been made.

Cancellation Policy: A 24-hour notice is required if you are unable to keep your appointment.

Etiquette: Throughout your body treatment you are discreetly covered. Inappropriate actions or language is cause for termination of treatment. We reserve the right to refuse service to anyone.

Signature: ____ Date: ____