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

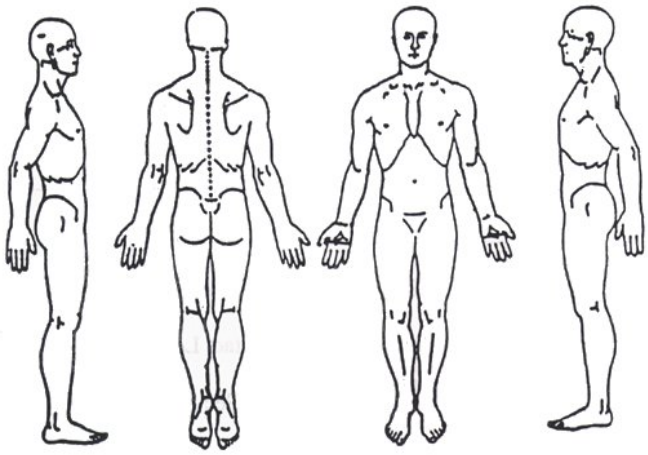
_____

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: _____

CLIENT COVID-19 INFORMATION & CONSENT

According to the Centers for Disease Control and Prevention (CDC), people of any age with these underlying health conditions are at increased risk for developing severe illness from COVID-19.

- People 65 years or older
- Children who are medically complex with underlying health conditions
- Women who are pregnant
- People with neurologic conditions (e.g., dementia)
- People with chronic obstructive pulmonary disease People with pulmonary fibrosis
- People with moderate to severe asthma
- People with cystic fibrosis
- People with serious heart conditions
- People with hypertension (high blood pressure)
- People with sickle cell disease People with thalassemia (a type of blood disorder)
- People with cerebrovacular disease (affects blood vessels and blood supply to the brain)
- People undergoing cancer treatment
- Bone marrow or organ transplant recipients
- People with immune deficiencies from medications or use of corticosteroids
- People with HIV/AIDS
- People with obesity (BMI 30 or higher)
- People with diabetes (type 1 and type 2)
- People with chronic kidney disease and undergoing dialysis
- People with liver disease People who are smokers

INFORMED CONSENT

I understand that COVID-19 is highly contagious and still present in the community where I am seeking massage therapy. I understand that COVID-19 is passed through close contact with others and that people without symptoms may be infectious. I understand that this massage business has taken every precaution to ensure my health and safety but that risk of infection is still possible.

_____ (Signature and date)

HIGH RISK AWARENESS

I understand that the heath conditions listed on page 2 of this document place me or my dependent at higher risk for serious illness from COVID-19 infection. If I have one of these conditions I or my dependent should forgo massage therapy while COVID-19 is still present in my community, or obtain my physician's consent to receive massage therapy. Should I or my dependent decide to proceed with massage therapy I assume all risk related to illness from COVID-19 infection.

_____ (Signature and date)

DEPARTMENT OF HEALTH AND EXPOSURE TO COVID-19

I understand that in the event that a client, therapist, or staff member of this facility tests positive for COVID-19 within a time period that places me at risk of exposure, my name and contact information will be shared with the State Department of Health for their follow-up. In the event that I develop symptoms of illness within two weeks of my massage appointment, I will contact this massage facility immediately.

_____ (Signature and date)