

**Alternative
Health
Center
of Cary**



This information will help us meet your individual needs. Thank you for your cooperation.

**Client History
Massage Therapy**

Name	Date
Address	Zip
Phone: Home	Business
Occupation	Birth Date
Height	Male/Female
Marital Status	Glasses/Contacts
Referred By	

RESPONSIBLE FOR PAYMENT: _____self _____spouse _____insurance _____other: _____

What are your reasons for coming to our clinic? (Please circle any of the following and describe.)

____stress ____stiffness ____injury ____relaxation ____pain ____personal growth
____other _____

If discomfort is present, how did this condition develop? When did it first start? _____

HEALTH HISTORY: Please check if you have a history of any of the following in the past three years:

- | | | |
|---|--|---|
| <input type="checkbox"/> allergies | <input type="checkbox"/> dizziness | <input type="checkbox"/> nervousness |
| <input type="checkbox"/> arteriosclerosis | <input type="checkbox"/> edema | <input type="checkbox"/> neuritis: where? |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> epilepsy | <input type="checkbox"/> ovarian pain |
| <input type="checkbox"/> asthma | <input type="checkbox"/> painful gas | <input type="checkbox"/> overweight |
| <input type="checkbox"/> athlete's foot | <input type="checkbox"/> headache/migraine | <input type="checkbox"/> phlebitis/varicose veins |
| <input type="checkbox"/> back pain | <input type="checkbox"/> heart problems | <input type="checkbox"/> PMS |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> severe menstrual pain |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> hernia | <input type="checkbox"/> sciatica |
| <input type="checkbox"/> bursitis | <input type="checkbox"/> herpes | <input type="checkbox"/> sinusitis |
| <input type="checkbox"/> Candida | <input type="checkbox"/> hands: cold/numb | <input type="checkbox"/> skin disorder |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> feet: cold/numb | <input type="checkbox"/> spastic paralysis |
| <input type="checkbox"/> cancer | <input type="checkbox"/> HIV positive/AIDS | <input type="checkbox"/> stomach disorder |
| <input type="checkbox"/> carpal tunnel syndrome | <input type="checkbox"/> hypoglycemia | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> constipation | <input type="checkbox"/> indigestion | <input type="checkbox"/> TMJ syndrome |
| <input type="checkbox"/> severe depression | <input type="checkbox"/> insomnia | <input type="checkbox"/> any contagious disease |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> neck pain/stiffness | <input type="checkbox"/> other _____ |

Musculo-skeletal injury: (car accidents, sports injuries, falls, etc.) _____

Surgery: _____

Do any of your relatives suffer from chronic illness, or has any relative died of a degenerative disease (i.e., cancer)?

Are you currently under the care of a physician, psychiatrist, or counselor? _____

Name of practitioner(s): _____

Any medications? _____

LIFE STYLE:

Is your work stressful? Please describe: _____

Where does your body hold chronic tension? _____ Please circle the areas ⇨⇨⇨⇨⇨

Can you relax easily? _____ Are you easily excited or upset? _____

Do you use any form of stress management (i.e., meditation, autogenic training, etc.)? _____

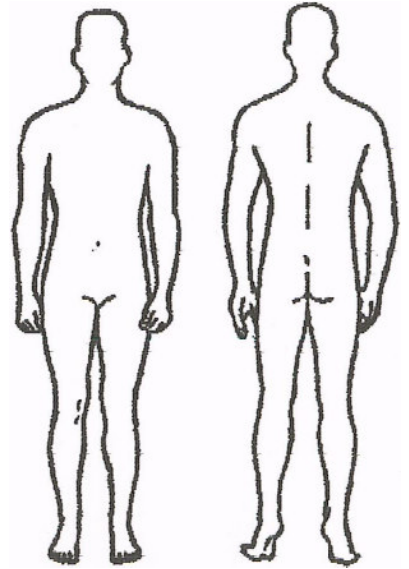
How many hours per week do you exercise? _____

Describe _____
Do you regularly use _____ coffee _____ alcohol _____ cigarettes

Any dietary restrictions? _____

How often do you receive therapeutic massage? _____

Have you ever received any form of structural bodywork? _____ Describe: _____



Please describe any feeling, symptom or problem with respect to your health, fitness or body structure not covered by our questions, which you feel should be noted and/or discussed: _____

Notes: _____

