Alternative Health Center of Cary

A Healthier Life...Naturally

CLIENT HISTORY
Massage Therapy

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

Name _____ Date _____

Address _____ Zip _____

Phone: Home _____ Business _____

Email Address _____

Occupation _____ Birthdate _____

Height _____ Weight _____ Male/Female _____

Marital Status _____ Glasses/Contacts _____

Referred By _____

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:

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

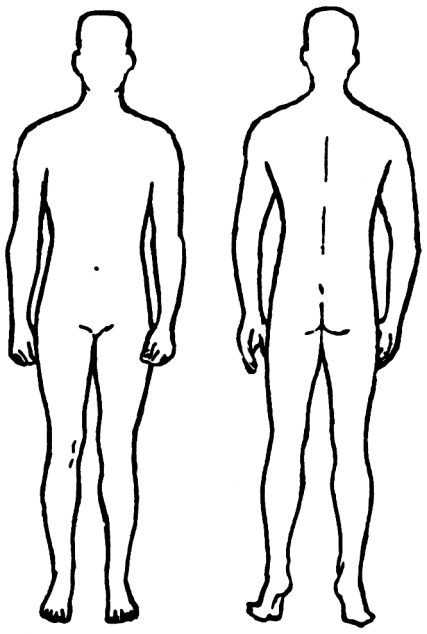
LIFE STYLE:

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: _____

_____

_____

_____

_____

_____

_____

_____

_____