UNC HEALTH CARE
WELLNESS CENTERS

Client Health History Form

Name_____ Date of Birth_____

Address_____

City/State_____ Zip_____

Telephone (H)_____ (W)_____ Email_____

Occupation_____ Member / Non-Member

Please fill in all the information requested below. All information will be kept confidential.

Referred to Massage Therapy by: _____

Reason for visit: Stress reduction Relaxation Pain Other_____

Primary area of complaint: _____

When and how did this condition develop: _____

If you currently have a fever, cold, or flu symptoms, Please reschedule your appointment

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Accidents/Injuries: _____

_____

Recent Hospitalizations/Surgeries: _____

_____

Medications currently taken: _____

_____

Are you under a health practitioner's care at this time? Yes_____No_____

If yes, for which conditions_____

List any known allergies: _____

Please check any condition(s) that apply to you. Please add your comments to clarify the condition(s).

Arthritis (type) _____ High/Low Blood Pressure _____

Blood Clots _____ Phlebitis _____

Cancer (type) _____ Kidney Problems_____

Circulatory Problems _____ Skeletal Problems_____

Diabetes (type) _____ Spinal Problems _____

Epilepsy _____ Stroke History _____

Heart Disease _____ Swelling/Edema _____

Fibromyalgia_____ Osteoporosis_____

TMJ _____ Varicose veins_____

Medical History Continued

Athlete's Foot_____ Abdominal Pain _____

Insomnia_____ Liver Problems_____

Back Pain _____ Headaches (type) _____

Chest Pain _____ Muscular injuries/ disease _____

Depression _____ Neurological injuries/ disease _____

Digestive Problems _____ Pancreas problems _____

Dizziness _____ Smoker_____

Fatigue _____ Reproductive issues_____

Carpal Tunnel Syndrome_____ Respiratory problems _____

Hernia/Rupture _____ Incontinence_____

Hypoglycemia _____ Skin Conditions _____

Pregnancy (if yes, how many weeks)_____ Warts_____

Other _____

I have listed all my known medical conditions and physical limitations and I will inform my massage therapist of any changes in my physical health. The Massage Therapist does not diagnose any medical, physical, or mental disorder nor prescribe medication or perform any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments that I may have. I understand the statements above and release the Massage Therapist and the UNC Wellness Centers from any and all claims of malpractice, non-disclosure, or lack of informed consent. I freely assume any and all risks of treatment whether presently contemplated or hereinafter discovered.

I understand that I am responsible for all payments of services rendered to me unless prior arrangements have been made. I understand that I will be responsible to pay for all appointments scheduled for me unless I call at least 24 hours prior to my appointment time to cancel or reschedule.

Signature_____ Date: _____

Print Name _____

If client is under the age of 18:

The undersigned hereby authorize and grant permission to the UNC Wellness Centers to administer massage therapy services to the client listed on this form.

_____ _____

(Parent/guardian signature) (Date)

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