K2 Massage Therapy

1637 Glenwood Ave. • Raleigh NC 27608 • 919-280-0131

Client Information & Health History

Please Print Clearly. All information shared will remain confidential.

Date: _______________

Name: ____ Sex: Male / Female

Address: ____

City: ______________________________________ State: __________________ Zip: ________________

Daytime Phone #: __________________________ Evening Phone #: ______________________________

Email: ____

Date of Birth: ______________________________ Occupation: ___________________________________

Referred By: ______________________________ Marital Status: Single / Married / Separated / Divorced

Primary Physician: ____

Emergency Contact (name & number): ____

Previous experience with massage therapy: ____

____

____

Present symptoms: What is your major complaint or condition you want to improve? ___________________

____

____

When did you first notice major complaints? ____

What brought it on? ____

____

What activities aggravate the condition? ____

____

Is this condition getting progressively worse? Yes / No

If yes, please explain: ____

____

What have you done to get relief? ____

____

Has there been a medical diagnosis? Yes / No

If yes, by whom? ____

Please explain: ____

____

Have you had X-rays or an MRI? Yes / No

If yes, by whom? ____

What are your intentions or expectations for this visit? _______________________________

____

____

Are you now under medical / therapeutic treatment? Yes / No

If yes, for what condition? ____

____

____

Please list your care provider's name and phone number: _____________________________

____

Current medications, including over-the-counter, herbs, supplements (last 6 months): ____________

____

____

List other therapies you receive: ____

____

Do you wear: Contact Lenses__________ Dentures/Removable Bridgework__________

Please describe, including dates, area of injury and treatment received:

Past Injuries or Accidents ____

____

____

____

Past Surgeries ____

____

____

Describe the exercise activities that you do (include frequency): _____________________________

____

____

____

____

Do you ever do any stretching or flexibility exercises? Yes / No

If yes, please explain: ____

____

____

What activities would you like to add to your exercise regimen? _____________________________

____

Please list any additional comments regarding your health and well-being: ______________________

____

____

____

____

Do you have or have you ever had any of the following conditions/illnesses/problems? Please check all that are applicable. Please be descriptive where appropriate (you may write on the back of this page).

Musculo-Skeletal
___Headaches or Migraines
___Joint stiffness/swelling
___Spasms/cramps
___Broken/fractured bones
___Strains/sprains
___Back, hip pain
___Shoulder, neck, arm, hand pain
___Leg, foot pain
___Chest, ribs, abdominal pain
___Problems walking
___Jaw pain/TMJ syndrome
___Tendonitis
___Bursitis
___Arthritis
___Osteoporosis
___Scoliosis
___Bone or joint disease
___Other: ____________________________

Circulatory and Respiratory
___Dizziness
___Shortness of breath
___Fainting
___Cold feet or hands
___Cold sweats
___Swollen ankles
___Pressure sores
___Varicose veins
___Blood clots
___Stroke
___Heart condition
___Allergies
___Sinus problems
___Asthma
___High blood pressure
___Low blood pressure
___Lymphedema
___Other: ____________________________

Skin
___Rashes
___Allergies
___Athlete's Foot
___Warts
___Moles
___Acne
___Cosmetic surgery
___Other: _______________

Digestive
___Nervous stomach
___Indigestion
___Constipation
___Intestinal gas/bloating
___Diarrhea
___Diverticulitis
___Irritable bowel syndrome
___Crohn's Disease
___Colitis
___Acid Reflux/Heartburn
___Other: _______________

Nervous System
___Numbness/tingling
___Twitching of face
___Fatigue
___Chronic pain
___Sleep disorders
___Ulcers
___Paralysis
___Herpes/shingles
___Cerebral Palsy
___Epilepsy
___Chronic Fatigue Syndrome
___Multiple Sclerosis
___Muscular Dystrophy
___Parkinson's Disease
___Spinal cord injury
___Other: ________________

Reproductive System
___Pregnancy
___Current ___Previous
___PMS
___Menopause
___Pelvic Inflammatory Disease
___Endometriosis
___Hysterectomy
___Fertility concerns
___Prostate problems

Other
___Loss of appetite
___Forgetfulness
___Confusion
___Depression
___Difficulty concentrating
___Drug use___________________
___Alcohol use_________________
___Nicotine use_________________
___Caffeine use_________________
___Hearing impaired
___Visually impaired
___Burning upon urination
___Bladder infection
___Eating disorder
___Diabetes
___Fibromyalgia
___Post/Polio Syndrome
___Cancer
___Infectious disease (please list)
____
___Other congenital or acquired disabilities (please list)__________
____
___Surgeries
___Other:________________________

For clients who need mobility assistance, please give your height:__________weight:__________

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature: ____ Date: ___________________________