Fast-Relief Therapeutic Massage
Rick Hersberger, LMBT # 6861
1289 N. Fordham Boulevard #E7,
Chapel Hill, NC 27514
Bus 919-449-6530 Hm 919-643-0232

Confidential Health History Questionnaire

Name: Date:

Address: City: St: Zip:

Email:

Home Phone Work Phone

Height/Weight / D.O.B.

Occupation Employer

Please circle any of the following conditions you currently have.

arthritis	muscular injuries	fatigue	varicose veins
Phlebitis	headaches	skin problems	Depression
diabetes	chronic pain	chest pain	Dizziness
respiratory problems	pregnancy	elimination problems	Circulation problems
hypertension	cardiovascular disease	communicable diseases	Neurological injuries/disorder

Other issues that may be of concern relative to receiving massage:

Please turn page.

Do you wear contact Lenses, dentures, or removable bridgework? (circle)

Are you currently under the care of a medical doctor, chiropractor or therapist?

If so, what for? _____

Approximate date of last physical. _____

May I contact your health care provider in order to best support your interests? __

What medications and/or supplements have you taken in the past six months?

_____

Please describe, past injuries, including dates, area of injury and treatments received (within past 6 months - longer if you believe it to be relevant to this therapy).

_____

Please indicate previous massage/bodywork received. _____

_____

What are your goals for today's visit and over the long term?

_____

Describe your typical physical activities and any regular exercise you get.

_____

Because a massage therapist must be aware of any existing physical conditions that I have, 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.

I understand and agree that: 1) the massage therapy that I am given is for the purpose of stress reduction, relief from muscular tension/spasm, and/or for improving circulation; 2) a massage therapist neither diagnoses illness, disease, or any other medical, physical or mental disorder, nor performs any spinal manipulations: 3) I am responsible for consulting a qualified physician for any physical ailments that I may have.

I agree that all services rendered to me are charged directly to me and I am responsible for payment unless prior arrangements have been made. I agree to pay for all scheduled appointments that I am unable to keep unless I notify my therapist more than 24 hours in advance.

Please remove necklace, bracelets, earrings and rings before your session.

Signature: _____ Date: _____