THE EDMUND CENTER OF NEUROMUSCULAR & MASSAGE THERAPY

Cornelius – 704-896-3656 • Mooresville – 704-662-8577 • Ballantyne – 704-502-4403

In order to maximize the effectiveness and safety of the massage session, please take time to carefully fill out this questionnaire. This information will be treated with the utmost confidentiality. Your feedback at the end of your massage is appreciated and will aid in tailoring your future sessions.

CLIENT INFORMATION

DATE____/____/ 20___

Name: Mr. Mrs. Miss. _____ Sex: _____ M _____ F

Address: _____

Street or Box # City State Zip

Telephone: Home ( )_____-_____ Work: ( )_____-_____

Date of Birth _____ Age _____ Height _____ ft_____ in Weight _____ lbs

Email: _____

PERSONAL INFORMATION

Reason for Appointment: _____

Occupation: _____

Leisure Activities, Exercise and Stress Reduction: _____

_____

Previous Massage/NMT Experience _____

_____

Referred by: _____

HEALTH HISTORY

Physician: _____ ( ) _____ - _____

Chiropractor: _____ ( ) _____ - _____

Other Practitioners: _____ ( ) _____ - _____

_____ ( ) _____ - _____

_____ ( ) _____ - _____

What When

Medical Treatment: _____

_____

_____

_____

What Taken For

Current Medications: _____

_____

_____

_____

Current or Recent Health Problems...

- ❑ accident
- ❑ disc problem
- ❑ hemophilia
- ❑ mid back pain
- ❑ broken bones
- ❑ joint ache
- ❑ low back pain
- ❑ varicose veins
- ❑ bruise easily
- ❑ neck pain
- ❑ heart attack
- ❑ HIV
- ❑ nervous tension
- ❑ abdominal pain
- ❑ stroke
- ❑ high blood pressure
- ❑ whiplash
- ❑ sprains
- ❑ seizures
- ❑ surgery
- ❑ diabetes-hypoglycemia
- ❑ cancer
- ❑ colitis
- ❑ vision / hearing
- ❑ heart or lungs
- ❑ circulation, blood pressure, blood clots
- ❑ digestion
- ❑ decreased range of motion
- ❑ sleep or fatigue
- ❑ arthritis, bursitis or gout
- ❑ breast augmentation
- ❑ allergies to oils or perfumes
- ❑ headaches
- ❑ dizziness
- ❑ jaw pain

Pregnancy _____ Trimester# _____

Do you currently have a bruise, lump, broken skin, rash sensitive or ticklish area?

_____

Do you **wear:** _____Contact lens _____Dentures _____ Hairpiece

Daily Habits

Posture assumed majority of the day _____

TOBACCO: _____ packs per day**/week**
ALCOHOL: _____ drinks per day**/week/month/year**
SLEEP: _____ hours per day
CAFFEINE: _____ sodas per day _____cups of coffee/tea per day

Do you experience any difficulty lying either on your stomach or your back?

Yes ___ No ___ If yes, please explain _____

_____

What is your goal/concern for today's session? _____

_____

Present symptoms: (What is your major complaint?)_____

Minor complaints: (Other areas of concern?): _____

Other comments: _____

_____

Signature _____ Date _____

Signature of Parent or Guardian _____