UNC
WELLNESS CENTERS
MEADOWMONT

Client History Health Form

Name Date

Home Address

Home Phone Work or Mobile Phone

Date of Birth Email

Member Non-member

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

Reason for visit:

Referred to Massage Therapy by:

Primary area of complaint:

When and how did this condition develop:

Accidents/Injuries:

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 at the bottom to clarify the condition(s).

- Arthritis (type)
- Blood Clots
- Cancer (type)
- Circulatory Problems
- Diabetes (type)
- High/Low Blood Pressure
- Phlebitis
- Pregnancy
- Skeletal Problems
- Spinal Problems

Medical History Continued

- Epilepsy
- Heart Disease
- Abdominal Pain
- Allergies
- Back Pain
- Chest Pain
- Depression
- Digestive Problems
- Dizziness
- Fatigue
- Hernia/Rupture
- Hypoglycemia
- Insomnia
- Stroke History
- Swelling/Edema
- Kidney Problems
- Liver Problems
- Migraine Headaches
- Muscular injuries/ disease
- Neurological injuries/ disease
- Pancreas problems
- Reproductive problems
- Respiratory problems
- Skeletal injuries/disease
- Other

Please clarify any condition(s)

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 Center at Meadowmont 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 to 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 Center at Meadowmont to administer massage therapy services to the client listed on this form.

___________________________________ _________________
(Parent/guardian signature) (Date)

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