3101 Guess Road Suite B
Durham, NC 27705
919-477-9887
www.bullcitysoles.com

Therapist: _____

Date: _____

____ Massage ____ Rolfing

Personal Information

First Name	Last Name	Date of Birth	Age

Address	City	State	Zip Code

Occupation	Email	Phone #	

Emergency Contact	Email	Phone #	Relationship

Do we have permission to contact you via email? Y/N Preferred method of contact: Email/Phone/Text

How did you hear about us? _____

Current Conditions

Have you ever received massage, cupping, or other types of bodywork before? If so, what type and when?

_____

Purpose/Objective for visit today? _____

How did this condition develop and when did it begin? _____

What makes it worse? _____

What makes it better? _____

Describe your daily physical activities at home and at work: _____

_____

Please rate your stress level on a scale from 1 to 5 (5 being most stressed): _____

Pleaser rate your general health level on a scale from 1 to 5 (1 being excellent health): _____

Music Preference _____ Massage Pressure: (circle) Firm Medium Light

Complete Other Side

Health History

Muscle-Skeletal:

- ☐ Bone or Joint Disease
- ☐ Joint Stiffness/Swelling
- ☐ Broken/Fractured Bones
- ☐ Arthritis _____
- ☐ Sprains/Strains
- ☐ Low Back/Hip/Leg Pain
- ☐ Neck/Shoulder/Arm Pain
- ☐ Jaw Pain/TMJ
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Spasms/Cramps
- ☐ Headaches/Head Injury
- ☐ Fibromyalgia

Circulatory/Respiratory:

- ☐ Heart Condition
- ☐ Varicose Veins
- ☐ Blood Clots
- ☐ High/Low Blood Pressure
- ☐ Lymphedema
- ☐ Breathing Difficulty
- ☐ Stroke

Reproductive:

- ☐ Pregnancy _____ weeks
- ☐ PMS
- ☐ Breast Implants (w/in 9 mths)
- ☐ Endometriosis

Digestive:

- ☐ Diverticulitus
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Crohn's Disease
- ☐ Constipation

Other:

- ☐ Anxiety
- ☐ Cold/Flu
- ☐ Depression
- ☐ Diabetes
- ☐ PTSD
- ☐ Allergies _____
- ☐ Asthma
- ☐ Hernia
- ☐ Past Physical/Emotional Abuse

Additional Information

Please list any medications/supplements you take regularly:_____

_____

Please list any surgeries not listed previously: _____

_____

I have listed all my known medical conditions and physical limitations to the best of my knowledge and I will inform my therapist of any changes in my physical health. I agree to communicate any time I feel like my well-being is being compromised.

I understand and agree: 1) the bodywork I am receiving is for the purposes of stress reduction, relaxation, pain relief, improving circulation, and/or relief from muscle tension; 2) there is the possibility of discolorations that can occur from Cupping Therapy. This reaction is not bruising and will dissipate within a few hours to as long as two weeks, in some cases; 3) the therapist neither diagnoses illness, disease, or any other medical, physical, or mental disorder, nor performs any spinal manipulations; 4) I am responsible for consulting a qualified physician for any ailment I may have.

I understand that all services rendered are my personal responsibility and payment is due at the time of service unless prior arrangements have been made. Please note that a 24-hour cancellation is required or a fee will be charged.

Children may not be left unattended in our lobby during session.

Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

For client under the age of 18 years old.