Duke Center for Living
at Fearrington

CONFIDENTIAL CLIENT PROFILE

Client Name _____

Address _____ City _____ ST _____ Zip _____

Home Phone _____ Work Phone _____

Male _____ Female _____ Date of Birth _____ Occupation _____

Contact Lenses? Y____ N ____ Emotional Stress? Y ____ N ____ Dentures? Y ____ N ____

Pregnant? Y ____ N ____ How many weeks? _____ Occupational Stress? Y ____ N ____

Exercise Activities _____

Relaxation Activities _____

Have you received therapeutic massage before? Y ____ N _____ What type? _____

Are you currently under a physician's care? Y ____ N ____

If yes, what condition(s)? _____

What medications are you taking? _____

List significant injuries and surgical operations with dates: _____

Do you have any needs that require special attention (current pain, discomfort, complaints)? _____

Mark all that apply:

___ low back pain	___ nonunion fracture	___ poor circulation	___ depression
___ mid back pain	___ insomnia	___ numb hands/feet	___ dizziness
___ tight shoulders	___ fibromyalgia	___ ulcers	___ chronic fatigue
___ stiff neck	___ hernia	___ herniated disc	___ stress
___ feet pain	___ arthritis	___ stroke	___ high blood pressure
___ joint pain	___ bursitis	___ seizure	___ low blood pressure
___ sciatic pain	___ allergies	___ tuberculosis	___ diabetes
___ TMJ pain	___ sinusitis	___ cerebral palsy	___ hepatitis
___ headaches	___ asthma	___ digestive disorders	___ thyroid disease
___ edema	___ skin disorders	___ constipation	___ heart disease
___ cancer	___ varicose veins	___ phlebitis	___ multiple sclerosis
___ nervousness	___ Parkinson's disease		

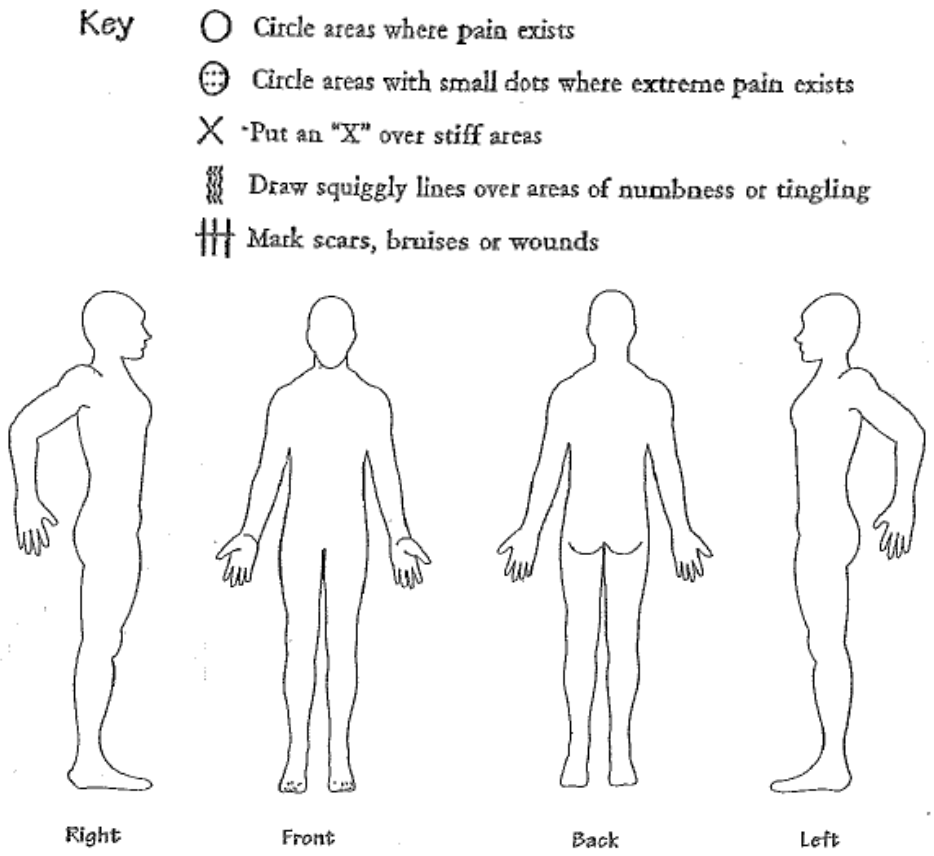
I understand that massage is not a substitute for care by a physician. I further understand this information is provided to assist the massage therapist in providing appropriate care and service, which is not to be construed as medical treatment. I realize a massage therapist needs to be aware of existing physical conditions. With this in mind, I have stated all past and current conditions and will keep the massage therapist informed of any changes.

Client Signature _____ Date _____

Client Status Report

Name:_____ Date:_____

Please identify current problem areas in your body by drawing the appropriate symbols on the diagrams below.



Date	Updates	Client Initials