WAKE TECHNICAL COMMUNITY COLLEGE
Student Clinic

TO THE CLIENT

This is a practice massage performed by a student of WTCC Therapeutic Massage Program. In accordance with the school's rules and regulations, students are not allowed to receive compensation in any form for these practice sessions. Practice sessions out side of the classroom environment are required as part of the school's curriculum to help students better prepare for working with the general public.

Thank you for participating in the training of our students.

By signing this document you have:

1. agreed to receive this practice massage from a student that is not licensed in this state as a massage and bodywork therapist
2. indicated in the Client History section, all medical conditions/medications your are aware of and will advise the student if any discomfort is experienced
3. understood that there may be certain health conditions which will prohibit receiving a student massage
4. the right to terminate the session at your own discretion should you feel the need to do so

_____ _____

Signature Date

CLIENT HEALTH HISTORY (To be filled out by the client)

Name _____ Date of Birth _____

Address _____ Phone _____

Occupation _____

Have you ever received a massage before? _____ If yes, how frequently? _____

Please check any of the health conditions listed below that you have had, currently have, or symptoms you may be experiencing:

__ headaches
__ broken bones
__ shortness of breath
__ high blood pressure
__ dizziness
__ interrupted sleep
__ seizures
__ other

__ heart problems
__ digestive problems
__ ulcers
__ joint pain/stiffness
__ blood disorder
__ respiratory disorder
__ anxiety/depression

__ numbness/tingling
__ diabetes
__ fibromyalgia
__ arthritis
__ cold hands/feet
__ varicose veins
__ HIV

__ kidney problems
__ chronic pain
__ cancer
__ skin condition
__ fatigue
__ allergies
__ recent surgeries
__ are you pregnant?

Please explain any of the above, including dates or time frames

List any prescribed medications you are now taking:

Are you wearing contact lenses, hearing aids or dental appliances? _____

Do you have any sensitivities to lotions, creams or scents that you are aware of? _____

What type of physical activity do you regularly participate in? _____
_____

Please describe areas of pain or concern: _____
_____

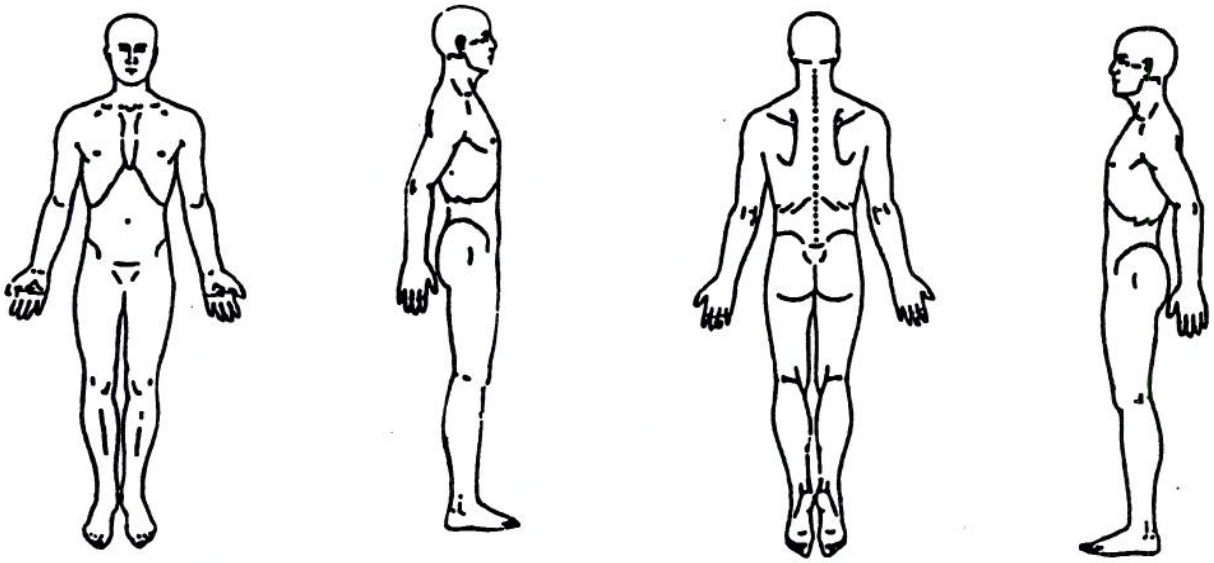
When did you first notice the discomfort? _____ What brought it on? _____

What activities continue to aggravate the symptoms? _____

Is there a medical diagnosis? _____

On a scale of '0' to '10' how would you rate your pain? _____ (0=no pain; 10=emergency room level)

Please use the figure to indicate specific areas of soreness or tension that you are currently experiencing:



Student Name _____ Date _____