Balanced Blend Therapeutic Massage

CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

First Name:_____M.I._____Last _____

Address:_____City:_____State: _____ Zip:_____

Phone (h):_____(w)_____ (C)_____

Occupation:_____ Date of Birth:_____

Emergency contact:_____Phone:_____Relationship:_____

Referred by:_____

E-mail:_____

Is this your first professional massage?_____ If no, how frequently do you get a massage?_____

What did you like or dislike about your massage ?

_____

What are your goals/expectations for this visit? _____

_____

Females: Are You Pregnant? ____ Please Note Pregnant women Cannot Be Massaged In The First Trimester

Please List The Date And Description Of Any Accidents Or Operations:_____

_____

Do You Have Any Chronic, On Going Pain That You Deal With On A Regular Basis?____

Pleaseexplain:_____

Describe What Activities Cause This Pain And/Or Make It Worse:_____

_____

Are you receiving any other type of medical treatment ?_____

Please Explain: _____

Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals :

_____

Are you currently under the care of a physician?_____

Please list conditions:_____

Are there any other health concerns you wish to discuss today?_____If yes, please describe:_____

Are you currently experiencing any of the following conditions?

_____ Flu or Cold _____ Inflammation _____ Fever _____ Infection _____ Contagious Disease

Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

CIRCULATORY

___ Anemia
__ Reynaud's Disease
__ Varicose Veins
___ Hemophilia
__ Heart Condition
__ Blood Clots/Phlebitis
___ Hypertension
__ Diabetes
__Other _____
___ Low Blood Pressure

DIGESTIVE

___ Ulcers
__Gallstones
__Hepatitis
___ Irritable Bowel Syndrome
__ Crohn's Disease
__ Diarrhea
___ Colitis
__Hepatitis
__ Gas/Bloating
___ Indigestion
__ Other _____

SKIN

___ Fungal Infections
__ Dermatitis/Eczema
__Psoriasis
___ Acne
__Impetigo
__ Open Wound or Sore
___ Impetigo
__ Rash
__ Warts/Moles
___ Athletes Foot
__ Other _____

NERVOUS SYSTEM

___ ALS
__ Bell's Palsy
__ Neuritis
___ Multiple Sclerosis
__ Spinal Cord Injury
__ Stroke
___ Parkinson's Disease
__ Seizure Disorders
__ Numbness/Tingling
___ Trigeminal Neuralgia
__ Other _____

MUSCULOSKELETAL

___ Fibromyalgia
__ TMJ
__ Cysts
___ Spasms/Cramps
__ Bursitis
__ Plantar Fascitis
___ Sprains/Strains
__ Tendonitis
__ Whiplash
___ Osteoporosis
__ Carpal Tunnel
__ Sciatica
___ Gout
__Headache
__ Thoracic Outlet Syndrome
___ Osteoarthritis/Rheumatoid Arthritis
__ Leg Pain
__ Low back Pain
__ Arm/Shoulder Pain
__ Mid Back Pain
__ Hip Pain
__ Other _____

RESPIRATORY

___ Pneumonia
__ Trouble Breathing
__ Dizziness
___ Sinusitis
__ Asthma
__ Other _____

OTHER

__ Insomnia
__ Anxiety
__ Panic Attacks
__ PMS
__ Cancer
___Edema
__ Chronic Fatigue
__ HIV/AIDS
__ Lupus

__ Kidney Disease __ Bladder Infection ___ Other _____

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose illness, disease or any other mental or physical disorder. Massage therapists do not prescribe medications or perform spinal manipulations. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my massage therapist to any changes in my physical, mental or emotional health.
If I experience pain or discomfort, I will immediately inform the massage therapist so that pressure or techniques may be adjusted to the level of my comfort.

Minor children age 18 and under must be accompanied by a parent or guardian. The parent or guardian of minor children age a16 and under must have a parent or guardian present in the room with the child during the session.
The parent or guardian of a minor child age 16 to eighteen must remain on the premises.

I understand that cancelled or missed appointments without 5 hours notice will be charged 50% of the session fee.

Client Signature_____ Date_____

Parent/Guardian Name _____ Date_____

Signature _____