

Body in Balance

Welcome

Medical History

Name _____ Date _____

Address _____ City/Town _____

State _____ Zip Code _____ Phone# _____ Cell# _____

E-mail _____ Referred by _____

Date of Birth _____ Occupation _____

Primary Physician _____ Date of last Physical _____

Medications (use other side if necessary) _____

What is your previous massage experience?

What is your reason for choosing massage? What results do you expect from this treatment?

What is your exercise routine?

Please circle any of the following that pertain to you: (please describe further on side)

Allergies	Depression	Phlebitis/Blood
Arthritis	Diabetes	Pins/Pacemaker
Anxiety	Digestion Problems	Pregnancy
Anemia	Dizziness/Fainting	Psychiatric
Asthma	Endocrine Issues	Recent Surgery
Athlete's Foot	Fatigue	Respiratory
Bleeding/Bruising	Headaches	Seizures/Epilepsy
Blood Pressure Problems	Hepatitis	Sinus Problems
Bursitis	Hernia	Skin Conditions
Cancer	Joint Problems	Smoker
Cardiac Issues	Kidney/Urinary	Stress
Circulation Problem	Liver/Gall Bladder Neuritis	Ulcers
Cold Sweats	Muscle Strain/Sprain	Varicose Veins
Contact Lenses	Osteoporosis	Vertebral/ Disc Problems

Other (include any other conditions, syndromes, recent accidents and any information pertinent to your health status):

Please explain any conditions that you circled above:

(turn over)

Please mark on the diagram below where you hold your tension and/or pain:

LEFT SIDE

RIGHT SIDE

Our Policy:

Massage should not be construed as a substitute for medical examinations, diagnosis or treatment. The massage you receive is provided for the basic purpose of relaxation, stress reduction and release of muscle tension.

Because massage bodywork is contraindicated (should not be done) under certain medical conditions, it is your obligation to state all your known medical conditions, to keep the practitioner updated to any changes in your medical profile. There shall be no liability on the practitioner's part if you fail to do so.

Also, understand that any illicit or sexually suggestive remarks or advances made toward the practitioner will result in immediate termination of the session and you will be responsible for full payment of the full scheduled appointment.

Should you need to cancel an appointment, a 2 hour advance notice is required or you will be financially responsible for the full session time.

Client Signature: _____ Date: _____

Massage Therapist: _____