Body in Balance

Muscular Therapy

CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

First Name: _____ M.I. _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (h): _____ (c): _____ (w): _____

Birth Date: _____ / _____ / _____ Email Address: _____

Male☐ Female☐ Referred by: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Do you wear contacts? _____ Do you Exercise? _____ If yes, how: _____

How much water do you drink in a day? _____ Do you consider yourself stressed? _____

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

What do you hope to accomplish from today's massage? _____

Are you aware of any tension holding spots in your body? _____ If yes, location(s) _____

Describe any surgeries, hospitalizations, accidents or injuries you have had: _____

Less than 5 years ago: _____

More than 5 years ago: _____

What kind of care did you receive for your accidents or injuries? _____

Do you feel you have recovered from these events? _____ Please explain: _____

_____

Do you have any chronic, ongoing pain that you deal with on a regular basis? _____ Please explain: _____

_____

Describe what activities cause this pain and/or make it worse: _____

_____

Are you currently receiving any other type of medical or therapeutic treatment? _____ Please explain: _____

_____

Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals. Include an explanation of what the medication is used to treat: _____

_____

Are you currently under the care of a physician? _____ Whom? _____

Please list reason(s): _____

Are there any health concerns you wish to discuss today? _____ If yes, Please describe: _____

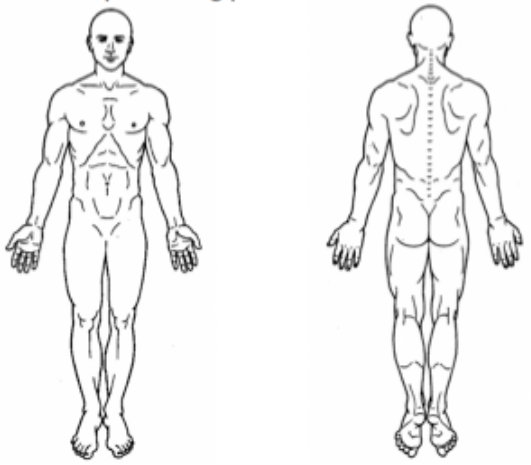
_____

_____

Are you currently experiencing any of the following conditions?

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

Please use the figures to indicate where you are experiencing pain or discomfort.



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

CIRCULATORY SYSTEM

__ Anemia
__ Hemophilia
__ Hypertension
__ Low Blood Pressure
__ Raynaud's Disease
__ Varicose Veins
__ Heart Condition
__ Blood Clots/Phlebitis
__ Diabetes
__ Swelling
__ Other_____

DIGESTIVE SYSTEM

__ Ulcers
__ Irritable Bowel Syndrome
__ Colitis
__ Gallstones
__ Hepatitis
__ Crohn's Disease
__ Diarrhea
__ Gas/Bloating
__ Indigestion
__ Bleeding
__ Constipation
__ Difficulty Swallowing
__ Other_____

SKIN

__ Fungal Infections
__ Acne
__ Impetigo
__ Dermatitis/Eczema
__ Psoriasis
__ Open Wound or Sore
__ Rashes
__ Warts/Moles
__ Athletes Foot
__ Other_____

RESPIRATORY SYSTEM

__ Pneumonia
__ Sinusitis
__ Asthma
__ Trouble Breathing __ Dizziness
__ Other_____

MUSCULOSKELETAL SYSTEM

__ Fibromyalgia
__ Spasms/Cramps
__ Sprains/Strains
__ Osteoporosis
__ Postural Deviations
__ Gout
__ Osteoarthritis/Rheumatoid Arthritis
__ TMJ
__ Cysts
__ Bursitis
__ Plantar Fascitis
__ Tendonitis
__ Torticollis
__ Whiplash Syndrome
__ Carpal Tunnel Syndrome
__ Sciatica
__ Thoracic Outlet Syndrome
__ Leg Pain
__ Ann Pain/Shoulder Pain
__ Low Back Pain
__ Mid Back Pain
__ Hip Pain
Other_____

NERVOUS SYSTEM

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

OTHER

__ Insomnia
__ Sleep Apnea
__ Anxiety/Panic Attacks
__ Physical/Emotional Abuse
__ Substance Abuse
__ Grief Process
__ Cancer
__ Chronic fatigue Syndrome
__ HIV/AIDS
__ Lupus
__ Kidney Disease
__ Bladder Infection
__ Postoperative Situation
__ Depression
__ Migraines
__ Frequent Headaches
__ Ear/nose/throat infection
__ Glaucoma
__ Visions problems
__ Other_____

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention and examination. I take full responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Signature _____ Date: _____