Balance Massage & Wellness Center

Client Health Questionnaire

Please fill out the appropriate information below. All information provided is kept in strictest confidentiality.

Name: _____

Address _____ Apt #: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____

Occupation: _____ Employer: _____

Date of Birth: _____ Email: _____

In Case of Emergency Please Notify: _____

Relationship to Client: _____ Phone: _____

Referred By: Name: _____

❑ Phone Book/Yellow Pages ❑ Newspaper/Magazine Ad

❑ Family Member ❑ Friend ❑ Other: _____

Preferred Appointment Day and Time: _____

Have you ever received a massage before? ❑ Yes ❑ No If so, by whom: _____

When?: _____

You are aware that you will be draped during the entire session? ❑ Yes ❑ No Initials _____ Date: _____

All cancellations with less than 24 hours notice may be subject to billing at the full rate.

Health History

Check any and all of the following conditions that currently apply to you, or have occurred within the last 12 months.

Musculo-Skeletal
- ❑ Headache
- ❑ Joint stiffness/swelling
- ❑ Spasms/cramps
- ❑ Broken/fractures bones
- ❑ Strains/sprains
- ❑ Back, hip pain
- ❑ Shoulder, neck, arm, hand pain
- ❑ Leg, foot pain
- ❑ Chest, ribs, abdominal pain
- ❑ Problems walking
- ❑ Jaw pain/TMJ
- ❑ Tendonitis
- ❑ Bursitis
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Bone or joint disease
- ❑ Other: _____

Circulatory and Respiratory
- ❑ Dizziness
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Cold feet or hands
- ❑ Cold sweats
- ❑ Swollen ankles
- ❑ Pressure sores
- ❑ Varicose veins
- ❑ Blood clotting
- ❑ Stroke
- ❑ Heart condition
- ❑ Pacemaker
- ❑ Allergies_____
- ❑ Sinus problems
- ❑ Asthma
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Lymphedemia
- ❑ Other: _____

Skin
- ❑ Rashes
- ❑ Allergies
- ❑ Athlete's foot
- ❑ Jock itch
- ❑ Warts
- ❑ Moles
- ❑ Acne
- ❑ Cosmetic/Reconstructive surgery
- ❑ Other: _____

Digestive
- ❑ Nervous stomach
- ❑ Indigestion/Gastritis
- ❑ Constipation
- ❑ Internal gas/bloating
- ❑ Diarrhea
- ❑ Irritable bowel syndrome
- ❑ Crohn's Disease
- ❑ Colitis
- ❑ Adaptive aids
- ❑ Other: _____

Nervous System
- ❑ Numbness/tingling
  Where?_____
- ❑ Twitching of face
- ❑ Fatigue
- ❑ Chronic pain
  Where?_____
- ❑ Sleep disorders
- ❑ Ulcers
- ❑ Paralysis
- ❑ Herpes/shingles
- ❑ Cerebral Palsy
- ❑ Epilepsy
- ❑ Chronic Fatigue Syndrome
- ❑ Multiple Sclerosis
- ❑ Muscular Dystrophy
- ❑ Parkinson's disease
- ❑ Spinal cord injury
- ❑ Pinched nerve
- ❑ Herniated Disc.
  Location?_____

Reproductive
- ❑ Pregnancy
- ❑ Current
- ❑ Currently menstruating
- ❑ PMS
- ❑ Menopause
- ❑ Pelvic Inflammatory Disease
- ❑ Endometriosis
- ❑ Hysterectomy
- ❑ Fertility concerns
- ❑ Prostate problems

Other
- ❑ Loss of appetite
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Difficulty concentrating
- ❑ Nicotine _____
- ❑ Caffeine _____
- ❑ Hearing impaired
- ❑ Visually impaired
- ❑ Burning upon urination
- ❑ Bladder infection
- ❑ Eating disorder
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Post/Polio Syndrome
- ❑ Tuberculosis
- ❑ Cancer
- ❑ AIDS/ARC/HIV
- ❑ Infectious diseases (please list)
  _____
- ❑ Other congenital or acquired disabilities (please list) _____
  _____
- ❑ Surgeries: _____
  _____
- ❑ Other: _____

Please provide any comments/concerns regarding your health history: _____

_____

_____

_____

General Information

Have you ever had a professional massage before? Yes or No
If yes, when was the last time you had one?_____

Do you have any difficulty lying on your front, back, or side? Yes or No
If yes, please explain:_____

Do you have allergic reactions to oils, lotions, ointments, liniments, or other substances put on the skin? Yes or No

Do you wear contact lenses ( ) dentures ( ) a hearing aid ( )?

Do you sit for long hours at a workstation, computer, or driving? Yes or No

Do you perform any repetitive movement in your work, sports, or hobby? Yes or No
If yes, please explain: _____

Do you experience stress in your work ( ) family ( ) other aspects of life ( )
If yes, please explain:_____

Is there a particular area of the body where you are experiencing tension, stiffness, or other discomfort? Yes or No
If yes, please describe:_____

Do you have any particular goals for this massage session? Yes or No
If yes, please explain:_____

Are you under Medical, Chiropractic, Physical Therapy, or Therapeutic treatment? ❑ Yes ❑ No

If YES, for what condition(s) ?: _____

_____

Do I have permission to contact your doctor, if necessary? (circle one) YES NO

Primary Care Providers Name, Address, and Phone Number: _____

_____

Please list ANY prescription medications, including ANY over-the-counter medications or herbal/nutritional supplements you are currently taking:

For Example : Aspirin, Ibuprofen, Aleve, Excedrine, Tylenol, Primatene, Metabolife, Vitamin/Mineral supplements.

_____

_____

Please list ANY known allergies:_____

_____

_____

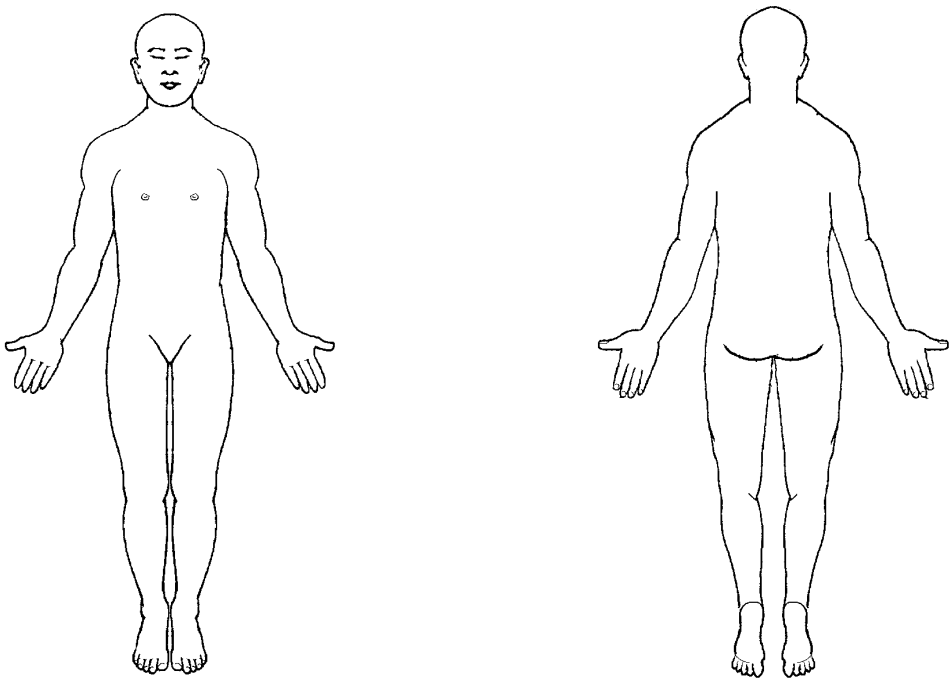
Comments: _____

_____

Present Symptoms/Condition

Name: _____ Date: _____

Please identify current or chronic problem areas in your body by drawing on the diagram below.



FRONT BACK

Please provide any comments/concerns regarding your present condition: _____

_____

_____

I have stated all conditions that I am aware of and the information I have provided is true and accurate. I will provide updates regarding any changes in my health condition, medications, supplements, or allergies.

Client's Signature: _____ Date: _____

Personal Information, Present Symptoms/Conditions, and Health History reviewed by:

Signature: _____ Date: _____

Balance Massage & Wellness Center

Policies and Procedures Agreement

1. *If a cancellation is necessary, please give at least 24 hours notice. No-shows may be charged the full fee, except in cases of emergency or if I can fill the slot with another client.*
2. *If there is an emergency and I cannot make your appointment, I will try to reach you by phone.*
3. *Please be on time and respectful of the next person who may be waiting for their appointment to start on time. Clients should be on the table and ready for their massage by five minutes after their appointment time. If a client is late, she/he may lose some of her/his time. If the therapist is late, she/he will compensate you for your time.*
4. *Clients are always draped between the sheets. This serves a dual purpose: to keep muscles warm that may have been massaged, and to protect the client's modesty.*
5. *Clients will determine how much clothing they feel comfortable removing.*
6. *The massage that you will receive is a non-sexual massage. It should also be clear that the service and intent of massage therapy is in no way similar to that of the so-called "massage parlors."*

I understand that massage therapy is the manipulation of the soft tissues for therapeutic purposes. Massage therapy is not meant to replace medical treatment, should the need arise.

I further understand that any medical diagnosis of my condition must be performed by a licensed medical practitioner and that I am advised to seek more appropriate treatment where indicated. I assume full responsibility for such consultation if necessary. I understand that massage therapy makes no claims to "cure" my condition.

I understand that I am responsible for communicating any physical or emotional discomfort, if any should arise, during the massage session. This may include, but is not limited to, temperature of room, music, depth of pressure, etc.

My signature below acknowledges that I have read, understand, and agree to adhere to the above policies.

*Client's Signature*_____ *Date*_____