Natural Balance Therapeutic Massage

Confidential Client Health History

DATE: _____

PERSONAL INFORMATION

NAME: _____BEST PHONE #:_____

ADDRESS: _____CITY/STATE/ZIP_____DOB:_____

OCCUPATION: _____EMAIL:_____

EMERGENCY CONTACT: _____RELATION:_____PHONE:_____

How did you hear about us? _____ if referred, by whom:_____

What is your main area of concern or discomfort?_____

CANCELLATION & LATE POLICY

24 hours advance notice is required for all cancellations and changes to appointments. Clients who "no show" or do not give 24 hour notice will be charged for that session. Clients arriving late will receive the remaining time of their scheduled appointment, so that the next client's appointment is not disrupted. Arriving 5 minutes early will help you relax and be ready to fully enjoy your massage. Please feel free to ask any questions or express any concerns regarding this policy. These guidelines are in place to protect the valuable time of both the client and the therapist.

I have read and accept the terms of this policy. Signature:_____ Date:_____

HEALTH HISTORY

Have you ever had a professional massage? ___Yes ___No If so, how long ago? _____

Do you have difficulty lying on your front, back or side? ___Yes ___No If yes, please explain_____

_____

Are you currently under the care of a medical doctor or chiropractor? ___Yes ___No If yes, please explain_____

_____Doctor/Chiro. Name:_____

Please list any medications or supplements you are taking. _____

_____

Do you bruise easily? ___Yes ___No

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Continued Health History

List all previous operations, accidents, injuries:_____

_____

Women: Are you pregnant? ___Yes ___No If yes, how many weeks?_____

PLEASE CIRCLE ANY OF THE FOLLOWING YOU CURRENTLY EXPERIENCE AND UNDERLINE ANY FROM PAST.

Headaches	Migraines	Thyroid problems	Fatigue	Depression
High blood pressure	Anxiety	Arthritis: type_____	Constipation	TMJ
Low blood pressure	Fibromyalgia	Cancer: type_____	Gout	Scoliosis
Carpal Tunnel Syn.	Varicose veins	Tumors/Cysts	Seizures	Stroke
Multiple Sclerosis	Osteoporosis	Bursitis: where_____	HIV/AIDS	Lupus
Plantar Fasciitis	Heart condition	Contagious skin disorders	Anemia	TB
Blood clots/Phlebitis	Dizziness	Tingling in arm/hands	Indigestion	PMS
Menopause	Cold hands/feet	Tingling in legs/feet	Insomnia	IBS
Internal pins/plates/screws	Spinal fusions	High Stress	Ulcers	Sciatica
Muscle spasms	Loss of balance	Low back pain	Neck pain	Fever
Bulging disc	Ruptured disc	Sinus trouble		

Is there anything else about your health history that you think would be useful for your massage therapist to know in order to plan a safe and effective massage session for you?_____

_____

Daily Habits: **Indicate using the legend.** **H = Heavy** **M = Moderate** **L = Light** **N = None**

Computer work:_____ How many hours per day_____ Caffeine_____ Tobacco_____

Alcohol____ Sugar_____ Water_____ Exercise_____ Relaxation_____

Do you wear contacts? ___Yes ___No Do you wear hearing aids? ___Yes ___No

I confirm that the above information is complete and correct and I will update my massage therapist of any changes to my health status. It is my choice to receive massage therapy. I understand the treatment being given is for the well-being of my body and mind, which includes stress reduction, relief of muscular tension, muscular spasm, muscular pain and/or increasing circulation and range of motion. I understand massage therapists do not diagnose illness or disease and I acknowledge that massage is not a substitute for medical treatment. I understand there shall be no liability on the therapists part should I fail to keep her/him up to date.

Signature of client_____ Date: _____