Health Information Form
Bio Balance Therapeutic Massage

Name_____ Date of initial visit_____

Address_____

City_____State_____Zip_____

Home phone _____Cell phone_____Work phone_____

Email(for contact and office use only, Never shared)_____

Occupation_____Reffered by_____

Emergency contact name_____ Number_____

Physicians name_____ Number_____

Massage experience

Have you ever had a professional massage before? Yes No

If yes, what type of massage are you used to (swedish, deep tissue, myofascial release, cranial sacral, etc.)?

_____

What are your goals for treatment?_____

Current Health

Do you exercise regularly and/or participate in any sports? Yes No

If yes, what kind of exercise/sports?_____

Do you perform any repetitve movements in your work, sports or hobby? Yes No

If yes, describe_____

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

If yes, describe_____

Do you experience stress in your work, family, or other aspect of your life? Yes No

If yes, describe_____

Have you recently had an injury, surgery, or areas of inflammation? Yes No

If yes, describe_____

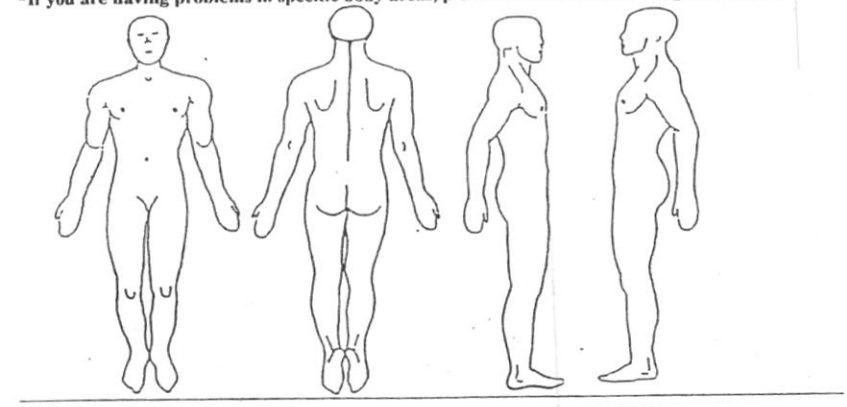
Do you have sensitive skin or any allergies to oils, lotions or ointments? Yes No

If yes, explain_____

List any known allergies_____

List any medications you are currently taking_____

*If you are having problems in specific body areas, please mark them on the diagrams below.



Please check all that apply to your health history

Musculoskeletal
___Bone or joint disease
___Tendonitis
___Arthritis/Gout
___Jaw Pain
___Lupus
___Spinal Problems
___Migraines/Headaches
___Osteoporosis
___Fibromyalgia

Circulatory
___Heart Condition
___Phlebitis/Varicose Veins
___Blood Clots
___High/Low Blood Pressure
___Lymphedema
___Thrombosis/Embolism

Respiratory
___Breathing Difficulty/Asthma
___Emphysema
___Sinus Problems

Nervous System
___Shingles
___Numbness/Tingling
___Pinched Nerve
___Chronic Pain
___Paralysis
___Multiple Sclerosis
___Parkinson's Disease

Reproductive
___Pregnant, Stage_____
___Ovarian/Menstrual Problems
___Prostate

Skin
___Rashes
___Cosmetic Surgery
___Athlete's Foot
___Herpes/Cold Sores

Digestive
___Irritable Bowel Syndrome
___Bladder/Kidney/Ailment
___Colitis
___Crohn's Disease
___Ulcers

Psychological
___Anxiety/Stress Syndrome
___Depression

Other
___Cancer/Tumors
___Diabetes
___Drug/Alcohol/Tobacco Use
___Contact Lenses
___Dentures
___Hearing Aids
Any other medical condition(s) not listed: _____
_____
_____
_____

Client Agreement

*It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.
*All client services and information are confidential.
*Payment is due in full upon completion of treatment session.
If you are unable to keep an appointment, please call with sufficient notice.
I understand that all no-call/no-show appointments will be billed in full directly to the client.
I have read the above statements, agree to the terms and declare the provided health information to be accurate.

Signature: _____ Date: _____

Thank you for selecting Bio Balance Therapeutic Massage as part of your health & wellness program.