Balanced Body Massage Client Intake Questionnaire

PLEASE PRINT NEATLY!

Name _____ Birth Date _____

Address _____ Home Phone _____

Cell or Business Phone _____

City _____ State _____ Zip _____ E-Mail _____

Occupation _____

Have you ever had massage therapy or bodywork before? _____ How frequently? _____

How did you learn about Balanced Body Massage? _____

Please check off any of the following conditions or symptoms which apply to, giving further explanation where needed:

- ☐ Sinus/Allergies _____
- ☐ Numbness/Tingling _____
- ☐ Shooting Pains _____
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Osteoporosis
- ☐ Hypoglycemia
- ☐ Hyperglycemia
- ☐ Diabetes
- ☐ Seizures/Convulsions
- ☐ Dizziness/Fainting
- ☐ Swelling/Edema _____
- ☐ Bruise Easily
- ☐ Varicose Veins
- ☐ Heart Condition
- ☐ Bursitis _____
- ☐ Arthritis _____
- ☐ TMJ/Jaw Pain
- ☐ Headaches _____
- ☐ Tendonitis _____
- ☐ Trouble Sleeping
- ☐ Constipation
- ☐ Diarrhea
- ☐ Irregular menstrual cycle
- ☐ Currently Pregnant

Please list and explain other conditions/symptoms you have or have experienced: _____

Have you had any serious or chronic illness, operations, or traumatic accidents in your lifetime? This is important to know so scar tissue, which can greatly affect your facial system and muscle function, can be addressed. _____

If yes, please explain: _____

Are you currently, or have you at any time within the last 12 months been under the care of a physician? _____

If so, for what condition? _____

If needed, do I have your permission to contact your doctor? _____

Doctor Name: _____ Phone: _____

List all medications you currently take - if you can't remember the name, note the condition the medication is treating:

_____

Do you exercise regularly? _____ Do you smoke? _____ Do you wear contact lenses? _____

Emergency Contact: _____ Phone: _____

I have completed this health form to the best of my knowledge. I understand that Massage Therapy and Bodywork services are a therapeutic health aid and are non-sexual. I understand that massage therapy does not diagnose illness or disease and that the massage therapist does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.

I understand that massage therapy is not a substitute for medical examination or medical care, and that it is recommended that I am concurrently working with my primary caregiver for any condition I may have.

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone or online, unless I have an emergency, in which case I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24 hour notice, I agree to pay any missed appointment charge applicable.

I have stated all my known physical conditions, medical conditions and medications and I will keep the massage therapist updated on any changes.

Client Signature _____ Date _____

Parent or Guardian Signature (if client under 18 years) _____