In Balance
Healing Massage & Bodywork Center

Medical History Form
PLEASE PRINT

Name (Mr. / Mrs. / Ms.):	Marital Status:	Date of Birth:
Occupation:	Gender:	
Address:	Town / Zip:	
Primary Phone (Home/Cell/Business):	Secondary Phone (H/C/B):	
Email:		
Primary Physician:	Date of Last Physical:	
Medications/Natural Supplements:		
How did you hear about us?	Is this your first massage?	
Is there a specific reason you are seeking massage at this time?		
Have you received any alternative treatments? If so what are they?		
What are your exercise habits?	Relaxation Techniques?	
What are your dietary habits?		
How much water do you drink?	Coffee?	Alcohol?

Circle any of the following conditions or issues that you have or have had from the list below:

Allergies
Alzheimer's / Dementia
Arthritis
Anemia
Anxiety
Asthma
Autoimmune
Back / Neck
Bladder
Bleeding / Bruising
Broken Bones
Blood Pressure
Blood Clots / Phlebitis
Bowel
Bursitis / Tendonitis
Cancer
Cataracts
Chest / Lung
Chronic Tension
Circulation
Clenching / Grinding
Cold Sweats
Constipation / Diarrhea
Contact Lenses / Glasses
Concussions / Contusions
Depression
Dental
Diabetes
Dialysis
Digestion
Dizziness / Fainting
Eye
Excessive Worry / Grief
Fatigue
Female Organ
Fibromyalgia
Fractures / Dislocations
Headaches / Migraines
Heart / Cardiac
Hepatitis
Hernia
Inflammation
Internal Hardware
Joint
Kidney / Gallbladder
Limited Range of Motion
Lyme
Lymphatic Disorder
Mental / Emotional
Mold Exposure
Mood Disorders
Neurological
Neuropathy
Osteoporosis
Pacemaker
Pinched Nerve
Pregnancy / Miscarriages
Prosethic Implant
Psychiatric
Respiratory
Restless Leg Syndrome
Scars
Sciatica
Scoliosis
Seizures / Epilepsy
Sinus
Skin Condition
Sleeping
Smoke / Drink
Spasms
Sprain / Muscle Strain
Stress
Stroke / TIA
Substance Abuse
Surgeries
Swelling
Thyroid
TMJ
Ulcers
Weakness / Numbness
Varicose Veins
Vertebral / Disc

Other: _____

Describe the circled above in detail. Make sure to include ANY accidents, births, dental procedures, falls, injuries, long-standing health matters, organ issues, syndromes, or anything pertinent to your health status from in utero to today. Use diagram on the back to indicate areas of injury or discomfort.

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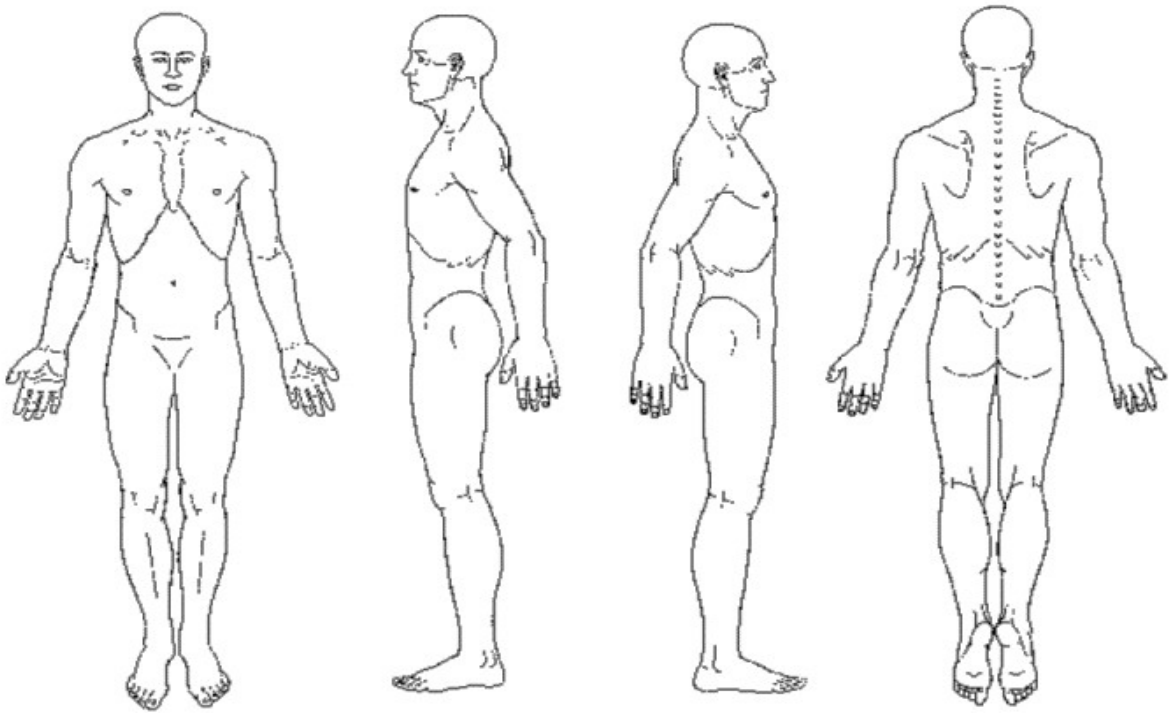
Please indicate on the drawings below where your pain is. Use the key to identify the type of pain you are feeling in that area.



FRONT LEFT SIDE RIGHT SIDE BACK

KEY

A - Ache
B - Burning
I - Inflammation
N - Numbness
P - Pins / Needles
R - Radiating Pain
S - Spasm
T - Tension
O - Other

Client Agreement

I understand that massage therapy is not a substitute for medical diagnosis or treatment, and that it is recommended I concurrently work with my Primary Caregiver for any condition I may have. I am also aware that the massage therapist does not diagnose illness or disease and does not prescribe medications. I have informed the massage therapist of all known physical / medical conditions, and I will keep the massage therapist updated on any changes in my health status and / or medications.

If you must reschedule a 24 hour notice is appreciated.
Same day cancellations will be billed at half price. No shows will be billed at the full price.
Emergencies are understood.

My signature hereby verifies the above information is complete and true, and that I agree to the above terms.

Print Name: _____ Date: _____

Sign Name: _____

Notes for your Practitioner: