# In Balance
## Healing Massage and Bodywork Center
## Medical History Form

PLEASE PRINT

| | | |
|---|---|---|
| Name: | (Mr. / Mrs. / Ms.) | Date of Birth: |
| Maritial Status: | Gender: | |
| Address: | Town / Zip: | |
| Phone (H/C): | Occupation: | |
| 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? | | |

**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
Back / Neck Pain
Bladder Issues
Bleeding / Bruising
Broken Bones
Blood Pressure Problems
Blood Clots / Phlebitis
Bowel Issues
Bursitis / Tendonitis
Cancer
Cataracts
Chest / Lung Issues
Circulation Problems
Clenching / Grinding
Cold Sweats
Constipation / Diarrhea
Contact Lenses / Glasses
Concussions / Contusions
Depression
Dental Problems
Diabetes
Digestion Problems
Dizziness / Fainting
Eye Issues
Fatigue
Female Organ Issues
Fibromyalgia
Fractures / Dislocations
Headaches
Heart Issues
Hepatitis
Hernia
Joint Issues
Kidney / Gallbladder Issues
Mental / Emotional
Mold Exposure
Neurological
Osteoporosis
Pins / Pacemaker
Pregnancy
Psychiatric
Respiratory
Scars
Scoliosis
Seizures / Epilepsy
Sinus Problems
Skin Condition
Sleeping Issues
Smoke / Drink
Sprain / Muscle Strain
Stress
Stroke / TIA
Substance Abuse
Surgeries
Thyroid Issues
Ulcers
Weakness / Numbness
Varicose Veins
Vertebral / Disc Problems

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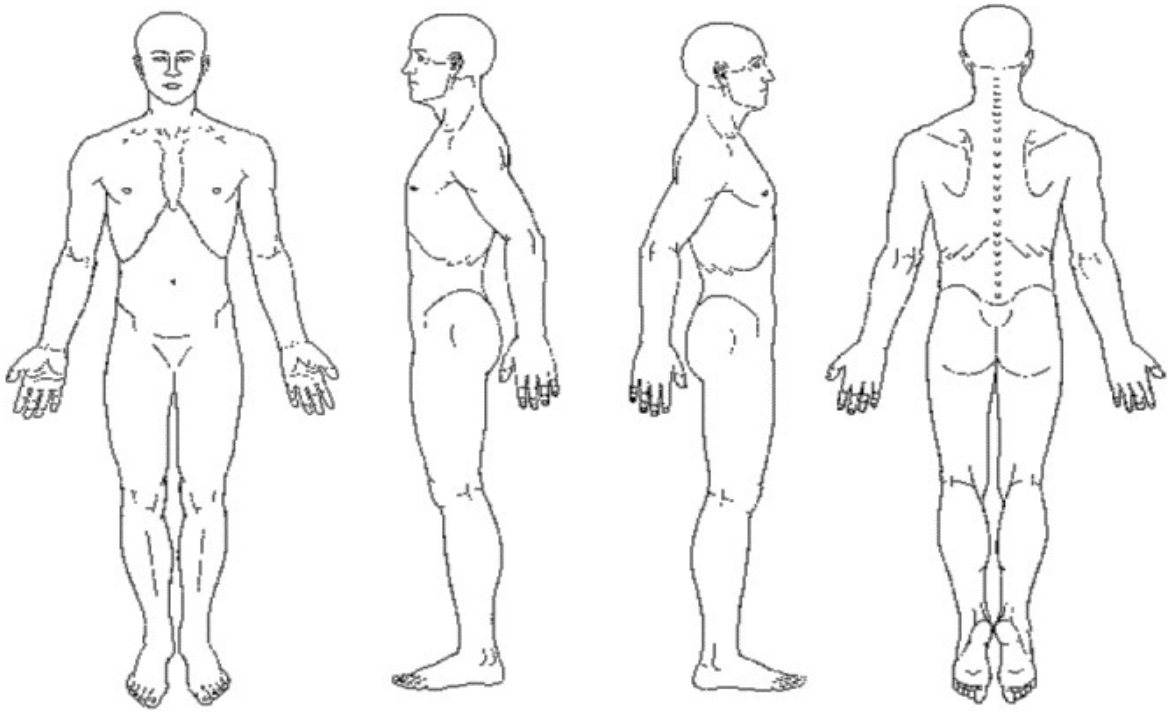
**Please indicate on the drawings below where your pain is.** Use the key to identify the type of pain you are feeling in that area.



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:**