

*Balance massage therapy*

## Client Health Questionnaire

Please fill out the appropriate information below. All information provided is kept in strictest confidentiality.

Name: \_\_\_\_\_

Address \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**In Case of Emergency Please Notify:** \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Spouse/Significant Other: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Children's Name(s) : \_\_\_\_\_

Date of Birth: \_\_\_\_\_

\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Referred By: Name: \_\_\_\_\_

Phone Book/Yellow Pages  Newspaper/Magazine Ad

Family Member  Friend  Other: \_\_\_\_\_

Preferred Appointment Day and Time: \_\_\_\_\_

Have you ever received a massage before?  Yes  No If so, by whom: \_\_\_\_\_

When?: \_\_\_\_\_

You are aware that you will be draped during the entire session?  Yes  No Initials \_\_\_\_\_ Date: \_\_\_\_\_

**All cancellations with less than 24 hours notice may be subject to billing at the full rate.**

# Health History

Check any and all of the following conditions that currently apply to you, or have occurred within the last 12 months.

## Musculo-Skeletal

- Headache
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractures bones
- Strains/sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease
- Other: \_\_\_\_\_

## Circulatory and Respiratory

- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Swollen ankles
- Pressure sores
- Varicose veins
- Blood clotting
- Stroke
- Heart condition
- Pacemaker
- Allergies \_\_\_\_\_
- Sinus problems
- Asthma
- High blood pressure
- Low blood pressure
- Lymphedema
- Other: \_\_\_\_\_

## Skin

- Rashes
- Allergies
- Athlete's foot
- Jock itch
- Warts
- Moles
- Acne
- Cosmetic/Reconstructive surgery
- Other: \_\_\_\_\_

## Digestive

- Nervous stomach
- Indigestion/Gastritis
- Constipation
- Internal gas/bloating
- Diarrhea
- Irritable bowel syndrome
- Crohn's Disease
- Colitis
- Adaptive aids
- Other: \_\_\_\_\_

## Nervous System

- Numbness/tingling  
Where? \_\_\_\_\_
- Twitching of face
- Fatigue
  - Chronic pain  
Where? \_\_\_\_\_
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/shingles
- Cerebral Palsy
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's disease
- Spinal cord injury
- Pinched nerve
- Herniated Disc.  
Location? \_\_\_\_\_

## Reproductive

- Pregnancy
  - Current
- Currently menstruating
- PMS
- Menopause
- Pelvic Inflammatory Disease
- Endometriosis
- Hysterectomy
- Fertility concerns
- Prostate problems

## Other

- Loss of appetite
- Forgetfulness
- Confusion
- Depression
- Difficulty concentrating
- Nicotine \_\_\_\_\_
- Caffeine \_\_\_\_\_
- Hearing impaired
- Visually impaired
- Burning upon urination
- Bladder infection
- Eating disorder
- Diabetes
- Fibromyalgia
- Post/Polio Syndrome
  - Tuberculosis
- Cancer
- AIDS/ARC/HIV
- Infectious diseases (please list)  
\_\_\_\_\_
- Other congenital or acquired disabilities (please list) \_\_\_\_\_  
\_\_\_\_\_
- Surgeries: \_\_\_\_\_  
\_\_\_\_\_
- Other: \_\_\_\_\_

For clients who need mobility assistance, please give your height: \_\_\_\_\_ weight: \_\_\_\_\_

Please provide any comments/concerns regarding your health history: \_\_\_\_\_

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## General Information

Have you ever had a professional massage before? Yes or No

If yes, when was the last time you had one? \_\_\_\_\_

Do you have any difficulty lying on your front, back, or side? Yes or No

If yes, please explain: \_\_\_\_\_

Do you have allergic reactions to oils, lotions, ointments, liniments, or other substances put on the skin? Yes or No

Do you wear contact lenses ( ) dentures ( ) a hearing aid ( )?

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

Do you perform any repetitive movement in your work, sports, or hobby? Yes or No

If yes, please explain: \_\_\_\_\_

Do you experience stress in your work ( ) family ( ) other aspects of life ( )

If yes, please explain: \_\_\_\_\_

Is there a particular area of the body where you are experiencing tension, stiffness, or other discomfort? Yes or No

If yes, please describe: \_\_\_\_\_

Do you have any particular goals for this massage session? Yes or No

If yes, please explain: \_\_\_\_\_

Are you under Medical, Chiropractic, Physical Therapy, or Therapeutic treatment?  Yes  No

If YES, for what condition(s)?: \_\_\_\_\_

\_\_\_\_\_

Do I have permission to contact your doctor, if necessary? (circle one) YES NO

Primary Care Providers Name, Address, and Phone Number: \_\_\_\_\_

\_\_\_\_\_

Please list ANY prescription medications, including ANY over-the-counter medications or herbal/nutritional supplements you are currently taking:

*For Example : Aspirin, Ibuprofen, Aleve, Excedrine, Tylenol, Primatene, Metabolife, Vitamin/Mineral supplements.*

\_\_\_\_\_

\_\_\_\_\_

Please list ANY known allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

# Present Symptoms/Condition

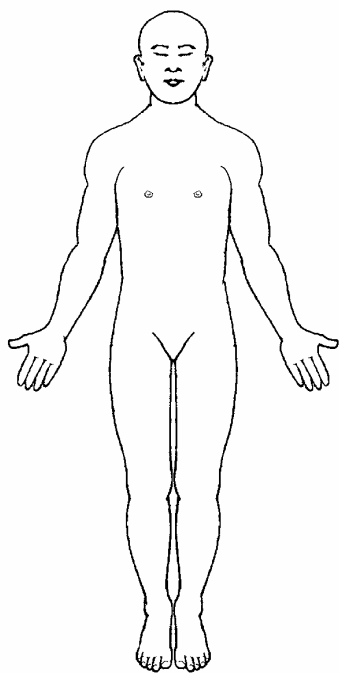
Name: \_\_\_\_\_

Date: \_\_\_\_\_

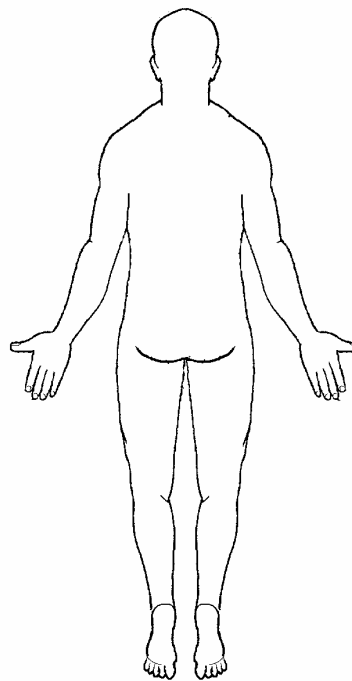
Please identify current or chronic problem areas in your body by drawing the appropriate symbols on the diagram below.

**Key:**

□		Place square on areas where chronic pain exists.
○		Place circle on areas where recent pain exists.
⊗ ⊕		Draw bars inside circle or square on areas where extreme pain exists.
X		Place an "X" on areas where stiffness occurs.
{ }		Draw squiggly lines over areas of numbness.
⌘		Mark scars, bruises, or wounds.



FRONT



BACK

Please provide any comments/concerns regarding your present condition: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**I have stated all conditions that I am aware of and the information I have provided is true and accurate. I will provide updates regarding any changes in my health condition, medications, supplements, or allergies.**

Client's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Personal Information, Present Symptoms/Conditions, and Health History reviewed by:**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# *Balance massage therapy*

## **Policies and Procedures Agreement**

1. *If a cancellation is necessary, please give at least 24 hours notice. No-shows may be charged the full fee, except in cases of emergency or if I can fill the slot with another client.*
2. *If there is an emergency and I cannot make your appointment, I will try to reach you by phone.*
3. *Please be on time and respectful of the next person who may be waiting for their appointment to start on time. Clients should be on the table and ready for their massage by five minutes after their appointment time. If a client is late, she/he may lose some of her/his time. If the therapist is late, she/he will compensate you for your time.*
4. *Clients are always draped between the sheets. This serves a dual purpose: to keep muscles warm that may have been massaged, and to protect the client's modesty.*
5. *Clients will determine how much clothing they feel comfortable removing.*
6. *The massage that you will receive is a non-sexual massage. It should also be clear that the service and intent of massage therapy is in no way similar to that of the so-called "massage parlors."*

*I understand that massage therapy is the manipulation of the soft tissues for therapeutic purposes. Massage therapy is not meant to replace medical treatment, should the need arise.*

*I further understand that any medical diagnosis of my condition must be performed by a licensed medical practitioner and that I am advised to seek more appropriate treatment where indicated. I assume full responsibility for such consultation if necessary. I understand that massage therapy makes no claims to "cure" my condition.*

*I understand that I am responsible for communicating any physical or emotional discomfort, if any should arise, during the massage session. This may include, but is not limited to, temperature of room, music, depth of pressure, etc.*

*My signature below acknowledges that I have read, understand, and agree to adhere to the above policies.*

*Client's Signature* \_\_\_\_\_ *Date* \_\_\_\_\_