PERSONAL INFORMATION AND MEDICAL HISTORY

Name___________________________ Date of Birth_________ Occupation_________________

Address____________________________City/State/ZIP__________________________________

Email___________________________ Phone_________________ Contact Method Call__Text__

Emergency Contact Name/Phone____

Referred by___________________________ How did you hear about us____________________

Have you ever received a professional massage? **Y / N** Goal of Treatment __________________

Are you currently pregnant? **Y / N** Due Date________________ Trimester 1st / 2nd / 3rd

Are you wearing Contact Lenses / Dentures / Hearing Aid / Prosthetics? Have Surgical Implants?

Do you have sensitive skin or allergies to any lotions or oils? **Y / N** Sensitive to smells? **Y / N**

Please circle if you have or ever had any of the following:

ADD/ADHD
AIDS/HIV
Allergies (Meds or Food)________________
Anemia
Anxiety
Arthritis Type_________________________
Body Dysmorphia
Broken Bones
Cancer Type________Treatment_________
Cardiovascular Disease
Carpal Tunnel
Circulatory Problems
Contagious Diseases
Cortisone Treatments
Depression
Diabetes Pre____ Type 1____ Type 2_____
Drug Addiction
DVT/Blood Clots
Epilepsy
Fibromyalgia

Headaches/Migraines
Hemophilia
Hypertension
Inflammatory Disease
Joint Replacement Location ____________
Low Blood Pressure
Lymph Node Removal
Mental Trauma
Osteoporosis
Phlebitis
Physical Abuse
PTSD
Seizures
Skin Conditions
Sprain/Strain
Stroke
Substance Abuse
Surgeries For/When___________________
Tendinitis
Varicose Veins

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Are you under a physician's care? **Y / N**   Name____________________Phone________________

Do you see a chiropractor? **Y / N**   Name____________________Phone________________

Are you taking any medications or supplements? **Y / N** Please list and what for_______________

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Please provide any additional information that you feel will enhance your therapeutic experience and allow the therapist to plan a safe and effective treatment plan ______________

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I have completed this information form to the best of my knowledge and agree to update the therapist to any changes in my health profile. I release the therapist of any liability if I fail to do so.
I have received, read, and understand the policies and procedures of Balance Bodyworks Holistic Health Center LLC. The therapist has informed me of her qualifications, the services to be provided, the benefits, risks, and goals of the session that we have agreed upon. I understand my right to withdraw my consent at any time during any session.
I understand that draping will be used during the session and that only the area being worked will be uncovered.
I understand that the massage services provided by Balance Bodyworks Holistic Health Center LLC are intended to promote relaxation and circulation and relieve stress, muscle tension, spasms, and related pain. I understand the massage therapist does not diagnose illness nor prescribe medical treatment or perform spinal manipulations and that massage therapy is not a substitute for medications or medical treatment.

Client Signature ____Date______________

Therapist Signature ____Date______________

Consent to treat a minor

I, the parent or legal guardian of (dependent's name)__________________________authorize Balance Bodyworks Holistic Health Center LLC to provide massage treatments to my dependent or child.
Parent or Guardian Signature _______________________________________Date______________