BACK N' BALANCE
MASSAGE & FUNCTIONAL TRAINING

Name: First_____ MI_____ Last_____

Address: _____ City: _____ State: ____ Zip: _____

Phone: Daytime: _____ Home: _____ Cell: _____

Email: _____ Birthdate: _____

Occupation: _____ Employer: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed

Referred By: _____

Emergency Contact: Name_____ Phone_____

Physician Name: _____ Practice: _____ Phone: _____

Massage Therapy History: □ First Professional Massage □ A few in my day □ Frequent Flyer

Pressure Preference: □ Deep □ Medium □ Light **Heat Preference for table**: □ No Heat □ Low □ Medium □ Hot

Massage Information

List accidents/injuries, hospitalizations and surgeries: When they occurred and treatment received

_____

_____

Any Lingering effects from the above or do you feel you have recovered?

_____

Chronic, ongoing pain? □ No □ Yes, please describe and any care or treatment you receive

_____

_____

Do Activities affect the pain? □ No □ Yes, please explain

_____

Are you currently being treated medically or taking prescription drugs? □ No □ Yes, please explain

_____

Please list all, prescription drugs, over the counter, supplements and or herbs taken and why

_____

_____

Primary Reason/Complaint for Seeking Massage Therapy

_____

_____

Exercise

Time/Day-Week: _____ Activities: _____

_____

Patient Conditions (helps determine treatment options)

Respiratory

□ Asthma □ Bronchitis □ Chronic Cough □ Emphysema □ Shortness of Breath
□ Pneumonia □ Other: _____

Cardiovascular/Circulatory

□ Blood Clots □ Cardiovascular Accident □ Cerebral-vascular accident □ Congestive Heart Failure
□ Heart Attack □ Heart Disease □ High Blood Pressure □ Low Blood Pressure
□Varicose Veins □ Pacemaker □ Phlebitis □ Stroke □ Myocardial Infarction
□Anemia □ Palpitations □ Mitral Valve Prolapsed □ Thrombosis/Embolism
□ Hemophilia □ Peripheral Artery Disease □ Raynaud's Disease □ Lymphedema

Skin Conditions

□ Hypersensitive Reaction □ Melanoma □ Skin Irritations □ Fungal Infections □ Impetigo
□ Athlete's Foot □ Eczema □ Dermatitis □ Psoriasis □ Herpes

Head & Neck

□ Ear Problems □ Headaches □ Hearing Loss □ Jaw Pain (TMJ) □ Migraines
□ Sinus Problems □ Vision Loss □ Vision Problems

Woman Specific

□ Gynecological Conditions □ Pregnancy □ PMS/Menopause □ C-Section

Musculoskeletal

□ Osteoporosis □ Arthritis □ Hypothyroidism □ Fibromyalgia □ Osteoarthritis
□ Chronic Fatigue □ Gout in _____ □ Bursitis □ Plantar Fasciitis □ Cysts/Lipomas
□ Tendonitis □ Whiplash □ Artificial Joints □ Surgical Pins/Plates □ Rheumatoid Arthritis

Soft Tissue/Joint Dysfunction

□ Ankles (left) □ Ankles (right) □ Arms (left) □ Arms (right)
□ Feet (left) □ Feet (right) □ Hands (left) □ Hands (right)
□ Hips (left) □ Hips (right) □ Knees (left) □ Knees (right)
□ Legs (left) □ Legs (right) □ Low Back (left side) □ Low back (right side)
□ Mid Back (left side) □ Mid Back (right side) □ Neck (left side) □ Neck (right side)
□ Shoulders (left) □ Shoulders (right) □ Upper Back (left side) □ Upper Back (right side)

Neurological

□ Cerebral Palsy □ Herniated Disc □ Multiple Sclerosis □ Parkinsons
□ Dizziness □ Bell's Palsy □ Neuritis □ Spinal Cord Injury
□ Seizures/Epilepsy □ Trigeminal Neuralgia □ Mental Illness

Other

□ Allergies □ Cancer □ Diabetes □ Insomnia
□ Crohn's Disease □ Digestive Conditions □ Lupus □ Loss of Sensation
□ Shingles □ Stress □ Grieving □ Anxiety/Panic Attacks
□ Kidney Stone □ HIV/AIDS □ On computer more than 2 hrs/day No. of hrs: _____

The above information is accurate. I understand that Massage Therapists do not diagnose disease or prescribe drugs and that they are not substitute for medical care. I agree to alert my practitioner of any physical/emotional changes as they occur. I also understand that a missed appointment might incur charges that I must pay.

Signature_____ **Date**_____