

Balanced Body Solutions

Confidential Health Intake Form

Today's Date: _____

Name: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____ Home Phone: _____

Cell/Pager: _____ Email: _____

Emergency Contact: _____ Phone: _____

Employer: _____ Occupation: _____

Medical History and Information

Check any or all that apply to your present health:

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Muscle or Joint Pain | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> High or Low Blood Pressure |
| <input type="checkbox"/> Jaw Pain/Teeth Grinding | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Cancer/Tumors |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Sleep Difficulties | <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Painful Menstruation | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Breast Augmentation | | |

List all medications/herbs/vitamins: _____

List physical activities you participate in regularly: _____

What movements or activities are limited? _____

List previous major injuries/surgeries: _____

What other treatments are you receiving and by who (acupuncture, physical therapy, chiropractic, naturopathic)? _____

What seems to help most? _____

What seems to aggravate the condition the most? _____

What is your main activity at work? On the Phone; Sitting; Computer Work; Driving Car/Truck;
 Walking; Other: _____

What do you do to relieve stress? _____

What do you want to get out of your session(s)? _____

Please read and sign:

I am responsible for all charges for all services provided. I understand the benefits and risks of massage and give my consent of massage. I will consult my practitioner with any questions or concerns immediately. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes. I agree to provide 24-hour cancellation notice. If I fail to do so I agree to pay the full appointment fee.

Signature _____ Date _____