balanced care
massage

Intake Form

Name _____ Phone _____ DOB _____

Address _____ City _____ State _____ Zip _____

Email _____

Referred by _____

Occupation _____ Male Female Physician _____

Health Insurance Carrier _____

In case of emergency _____ Phone _____

HEALTH HISTORY Please provide information for the past 5 years, including type, approximate dates and treatment.

Please list any surgeries • major illnesses • injuries: _____

_____

Please list any medications • vitamins • supplements you are currently taking: _____

_____

HEALTH CONDITIONS Please **circle** any current and previous conditions. A referral from your primary care provider may be required prior to service being provided.

General
Stress
Pain
Headaches
Infections
Numbness
Fatigue
Swelling
Altered Sensation
Sleep Disturbances
Allergies _____

Nervous System
Consussion
Anxiety
Head Injury
Depression
Stroke
Other _____

Cardiovascular and Respiratory
Anemia
Heart Attack
Heart Disease
Varicose Veins
Angina
Asthma
Hypertension
Blood Clots
Arteriosclerosis
Congestive Heart Failure
Irregular Heart Beat
Phlebitis
Other _____

Skin Conditions
Abrasions/Cuts
Rashes
Bruises

Muscles and Joints
Arthritis
Fractures
Bursitis
Disk Problems
Osteoporosis
Sprains
Tendonitis
TMJ
Scoliosis
Strains
Stiffness
Other _____

Endocrine System
Type 1 Diabetes
Type 2 Diabetes
Thyroid
Other _____

Digestion and Elimination
Heartburn
Bowel Problems
Gastric Reflux
Gas/Bloating
Ulcers
Urinary Tract Problems
Other _____

Reproductive System
Pregnancy (Y/N)
Due Date _____
PMS
Other _____

Cancer or Tumors
Benign
Malignant

By signing this, I agree that I have answered all questions to the best of my knowledge and that I will inform the therapist of any changes in my condition or medication. If I experience any pain/discomfort or would like the pressure adjusted, I will inform the therapist immediately. I understand that I will be receiving a therapeutic massage and that the purpose of this massage is to maintain good health and physical condition. I understand that the massage therapist may not diagnose or treat injuries or disease and that massage should not take the place of a doctor's care . I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Payment is required at the end of the massage session. I understand I may be charged up to the full amount of service for missed appointments or for any cancellations with less than a 24 hour notice. I agree that I am of legal age (18 years old) and that if I am not, I agree to have my parent or guardian sign a parental guardian release form before treatment.

Signature: _____ Date: _____