Balanced Bodywork Massage Therapy

(608) 769-5882 146 Rose Street La Crosse WI 54603
www.balancedbodyworkmassagetherapy.com

CLIENT NAME_____

BIRTH DATE_____

Mailing Address_____ Email_____
City, State, Zip_____ Telephone_____
Employer/Occupation_____ Daytime/work phone_____

Emergency Contact_____ Telephone_____
Primary Physician/Providers_____

Please, list any allergies you may have:

_____

How did you hear about Balanced Bodywork Massage Therapy? _____
Have you received therapeutic massage or bodywork in the past? YES NO How recently? _____
Do you receive any other treatments such as chiropractic, acupuncture, etc?

_____

What would you like to achieve from your massage therapy session(s)?

_____

_____

Is there anything else you feel I should know?

_____

_____

Therapeutic massage is intended to enhance relaxation, reduce pain, increase range of motion, improve circulation, and offer a positive experience of touch. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorders. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform skeletal manipulations. I understand that the massage is not a substitute for medical treatment or diagnoses and that it is recommended that I see a physician for any physical or mental ailments that I may have. I also understand that the therapist reserves the right to refuse to perform massage on anyone whom she deems to have a condition for which massage is contraindicated. I understand that at any time I may withdraw my consent and treatment will be stopped. Sexual advances of any kind will not be tolerated and the massage session will be terminated immediately.

All the information on the front and back of this form is accurate and complete. I understand that it is my responsibility to inform my therapist if there are any changes in my health and that massage/bodywork may not be appropriate for certain conditions or symptoms.

I have received a copy of Balanced Bodywork's policies; I understand them and agree to abide by them.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date_____

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CLIENT NAME Text_____

BIRTH DATE_____

Now	Past	Condition
		Headaches
		Head injury, concussion
		Seizures, epilepsy
		Memory loss
		Sleep disturbances
		Fatigue
		Dizziness/fainting
		Vision problems
		Contact lenses
		Sinus problems
		Ringing in ears
		Jaw pain, TMJ
		Dentures
		Whiplash
		Wrist pain, carpal tunnel
		Pins/needles
		Numbness, tingling
		Spinal problems
		Disk problems
		Scoliosis
		Sciatica, shooting pain

Now	Past	Condition
		Sprains/strains
		Tendonitis/bursitis
		Cortisone injections
		Stiff/painful joints
		Dislocated joints
		Joint replacements
		Broken bones
		Osteoporosis
		Osteoarthritis
		Rheumatoid arthritis
		Autoimmune disorder
		Thyroid dysfunction
		Fibromyalgia
		Depression
		Post-traumatic stress
		Smoking
		Difficulty breathing
		Asthma
		Chest pain
		Pacemaker
		Heart disease

Now	Past	Condition
		Heart attack
		Irregular heart beat
		High/low blood pressure
		Blood clots, thrombosis
		Stroke
		Poor circulation
		Varicose veins
		Swollen ankles
		Lymph edema
		Rashes, athlete foot, wart
		Diabetes
		Kidney disorder, disease
		Benign cancer/tumor
		Malignant cancer/tumor
		Chemotherapy/radiation
		Digestive issues
		Abdominal pain
		Miscarriage
		Fibrotic cysts
		Painful, irregular menses
		Pregnancy

List and Explain, including dates and treatments received:

Surgeries	Injuries/Accidents/Falls	Major Illnesses

Please, list all medications you are currently taking, including prescription, over-the-counter, supplements and herbs.

Name	Dosage	Reason

Comments:

_____

_____