

# NATURAL BALANCE MASSAGE

## CONFIDENTIAL INFORMATION

Welcome. We want to make your appointment as pleasant and comfortable as possible  
If at any time you have questions regarding your visit, please let us know.

Name: \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ M  F  Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_

Referred By \_\_\_\_\_

Email \_\_\_\_\_

Have you ever received massage therapy? Yes  No

Approximate date of last massage \_\_\_\_\_

How often are you taking medication? \_\_\_\_\_ Describe \_\_\_\_\_

Any Surgeries/Fractures/Medical Concerns? \_\_\_\_\_

Have you consumed alcohol in the past 24 hours? Yes  No

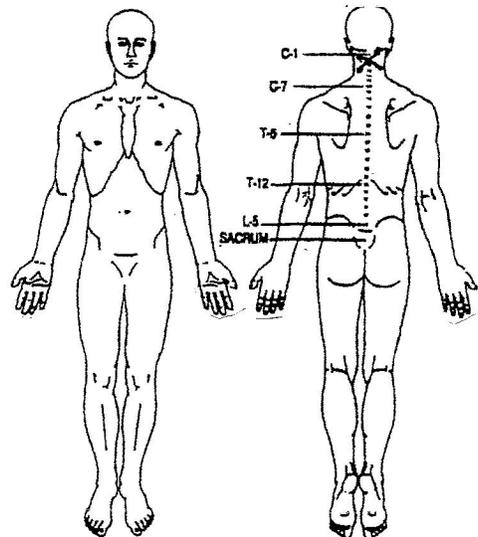
Do you have a history of any of the following?

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> accident      | <input type="checkbox"/> sprains/strains             | <input type="checkbox"/> fibromyalgia              | <input type="checkbox"/> neck pain      |
| <input type="checkbox"/> seizures      | <input type="checkbox"/> breast augmentation         | <input type="checkbox"/> whiplash                  | <input type="checkbox"/> abdominal pain |
| <input type="checkbox"/> diabetes      | <input type="checkbox"/> headaches                   | <input type="checkbox"/> nervous tension           | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> disc problems | <input type="checkbox"/> arthritis, bursitis, gout   | <input type="checkbox"/> high blood pressure       | <input type="checkbox"/> mid back pain  |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> allergy to oils or perfumes | <input type="checkbox"/> stroke                    | <input type="checkbox"/> joint ache     |
| <input type="checkbox"/> heart attack  | <input type="checkbox"/> decrease range of motion    | <input type="checkbox"/> contacts/other prosthetic | <input type="checkbox"/> colitis        |
| <input type="checkbox"/> cancer        | <input type="checkbox"/> fractures                   | <input type="checkbox"/> surgery                   | <input type="checkbox"/> HIV            |

Reason for your visit today? \_\_\_\_\_

PLEASE INDICATE WITH AN (X) THE  
PLACES YOU ARE FEELING DISCOMFORT

Any special requests? \_\_\_\_\_



PLEASE READ THE FOLLOWING AND SIGN BELOW:

- I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
- I am responsible for paying any appointment cancellation of less than 4 hours.

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Signature: \_\_\_\_\_