A Touch of Balance

Lonnie Smith
Or License #20854
541-281-9909

CLIENT INTAKE AND HEALTH HISTORY FORM

First Name_____Last Name _____M.I____ Date of Birth_____

Street Address_____City_____State_____ Zip_____

Phone_____Email_____

Emergency Contact_____Relationship_____Phone_____

Is this your first massage? Y N If No, how often?_____ Referred By: _____

What is your primary reason for massage today? _____

How would you rate your lifestyle: ___Very Stressful ___Moderately Stressful ___Mildly Stressful ___No Stress

Do you exercise? Y N How many times per week? _____ How much water do you drink per day? _____

If no exercise, are you physically active? Y N What type? _____

Check if you currently have or have experienced in the past:

Now	Past		Now	Past		Now	Past		Now	Past	
__	__	Headache/Migraine	__	__	Anxiety	__	__	Jaw Pain/TMJ	__	__	Sprains/Strains
__	__	Fever	__	__	Depression	__	__	Carpal Tunnel	__	__	Tendonitis
__	__	Contagious Illness	__	__	Fatigue	__	__	Sciatica	__	__	Numbness/Tingling
__	__	Varicose Veins	__	__	Dizziness	__	__	Bursitis	__	__	Tinnitus/Ringing Ears
__	__	Spasms/Cramping	__	__	Liver Disease	__	__	Hernia	__	__	Diabetes
__	__	Insomnia	__	__	Kidney Disease	__	__	Blood Clots	__	__	Arthritis
__	__	Skin Rash	__	__	Nervous Condition	__	__	Abdominal Pain	__	__	Circulation Problems
__	__	Skin Sensitivity	__	__	Epilepsy/Seizure	__	__	Constipation	__	__	Phlebitis
__	__	Open Sores/Wounds	__	__	Stroke	__	__	Digestive Problems	__	__	Hemophilia
__	__	Heart Condition	__	__	Cancer	__	__	Bone Fractures	__	__	Tenderness/Bruising
__	__	High Blood Pressure	__	__	HIV/AIDS	__	__	Osteoporosis	__	__	Chronic Pain
__	__	Low Blood Pressure	__	__	Other AutoImmune:	__	__	Respiratory Issues	__	__	Allergies:
__	__	Other _____			_____	__	__	Asthma			_____

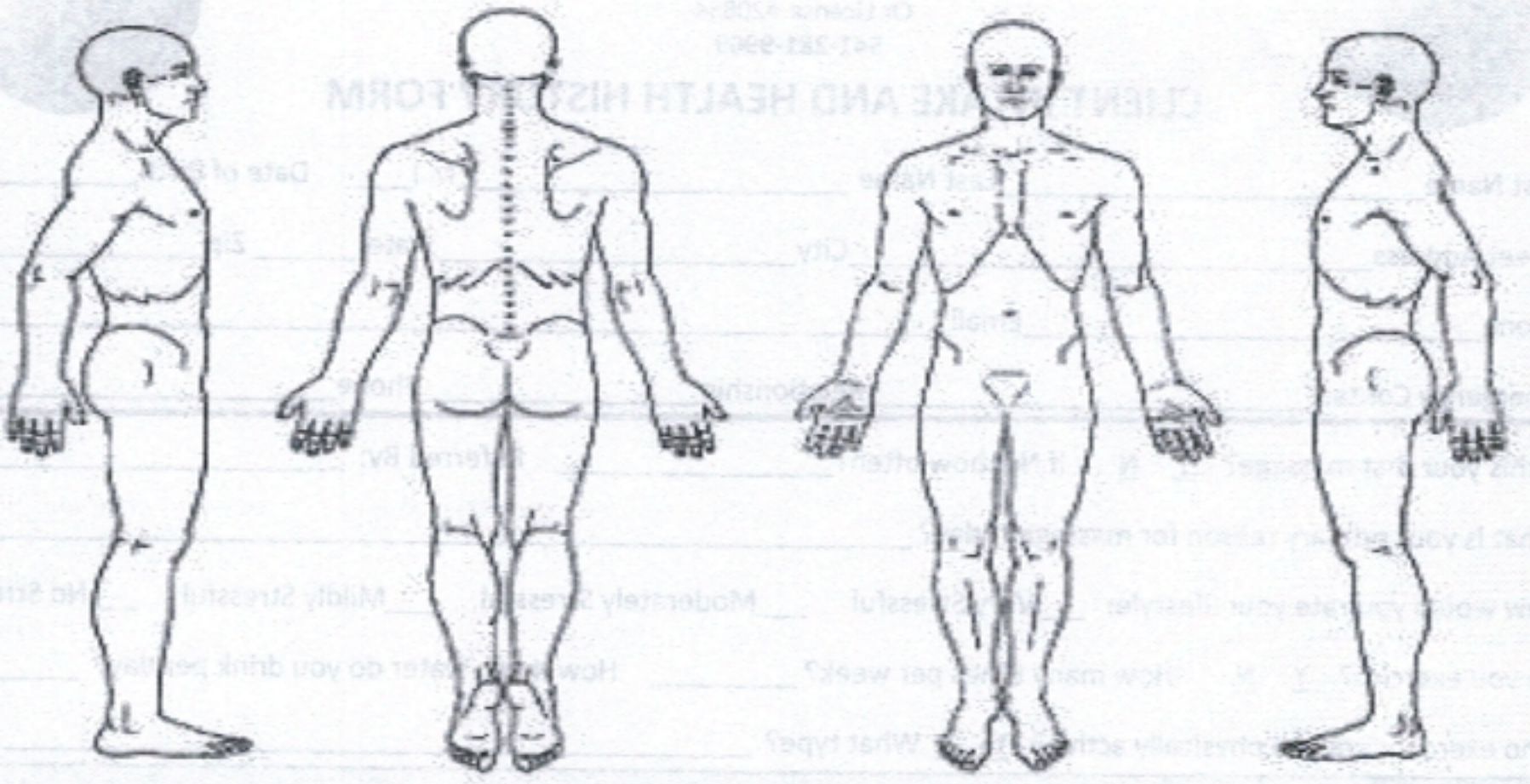
Are you currently under a physician's care? Y N If yes, for what? _____

Are you currently taking any medications? Y N If yes, what kind?_____

Do You Smoke? Y N If Yes, how much? _____ Females: Are You Pregnant? Y N

If yes, how long? _____ Are You Menstruating? Y N

In the chart below, please shade in all areas of pain or tenderness. Circle any areas that indicate numbness or tingling.



On a scale of 0 – 10 with 0 being no pain, how would you rate your pain today? 0 1 2 3 4 5 6 7 8 9 10

What type of pain or discomfort are you experiencing (i.e shooting, stabbing)? _____

Have you had any recent injuries? Y N Explain: _____

Are there any specific areas you would like massaged today? _____

Are there any areas you are very ticklish or would prefer not to be massaged today? _____

From the Practitioner:

I am here to help you attain your needs and goals in the most comfortable and professional manner. If at any time before, during, or after the massage treatment you feel there may be something that would help you, or if you experience any discomfort, I ask that you please make these issues available to discuss with me at any time. This is YOUR time to relax, and your input to achieve an optimal session is essential!

Thank you

==========

- ☐ I understand that massage can produce effects other than relaxation, such as muscle soreness and feelings of illness due to detoxification.
- ☐ I understand I will not receive any medical diagnosis by the practitioner, nor is this therapy a replacement for medical care. Any serious health condition may terminate the session until medical attention is sought.
- ☐ I have read and agree to the Therapist's "Policies and Procedures"

Signature of Client: _____ Date: _____