Therapeutic Balance New Client Intake

Personal Information

Name_____ Phone (day)_____(evening)_____

Address_____ City/State/Zip_____ DOB_____

Occupation_____ Employer_____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about Therapeutic Balance?_____

Are you taking any medications? Yes / No
If yes, please list name and use:_____
_____
_____

Are you currently pregnant? Yes / No
If yes, how far along? _____ Any high risk factors?_____
Do you suffer from chronic pain? Yes / No
If yes, please explain:_____
_____
_____
What makes it worse?_____
_____
_____
Have you had any orthopedic injuries? Yes / No
If yes, please list:_____
Please indicate any of the following that apply to you (please circle):
Cancer Headaches/Migraines Arthritis Diabetes Stroke

Joint Replacement High/Low Blood Pressure Neuropathy

Fibromyalgia Heart Attack Kidney Dysfunction Blood Clots

Numbness Sprains or Strains

Explain any conditions you have marked above: _____
_____
_____
_____
_____

Have you had a professional massage before? Yes / No
What type of massage are you seeking? Relaxation / Therapeutic/Deep Tissue
Other:_____
What pressure do you prefer? Light / Medium / Deep

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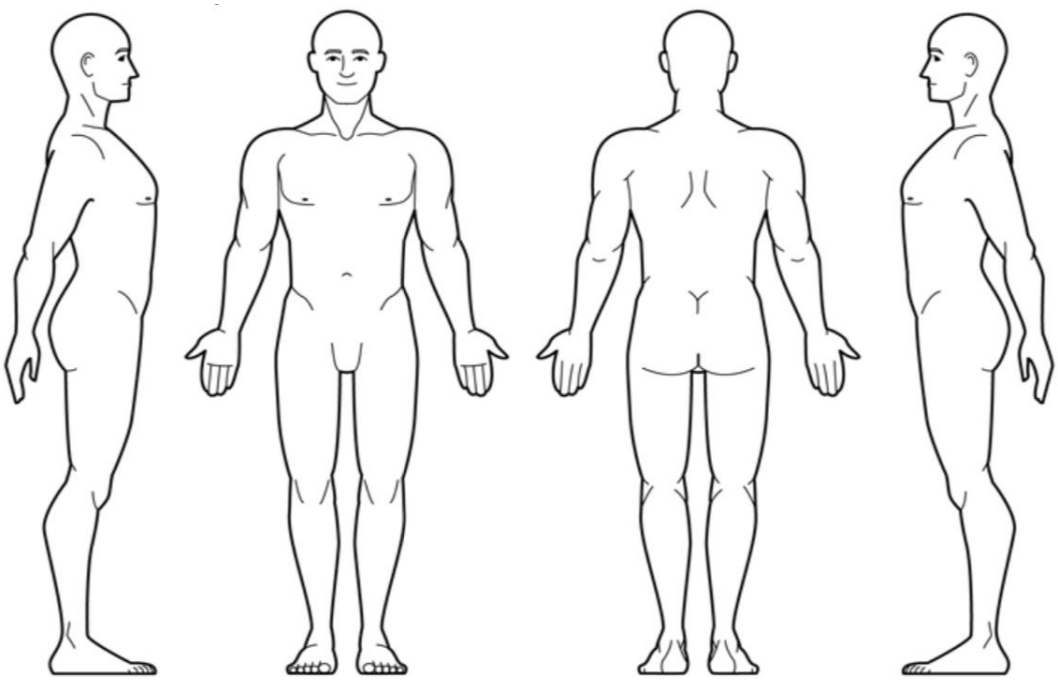
Do you have any allergies or sensitivities? Yes / No
Please Explain: _____
_____
_____

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? Yes / No
Please Explain: _____
_____
_____

What are your goals for this treatment session? _____
_____
_____

Please mark any areas of discomfort below:



By signing below, you agree to the following: I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____
Therapist Signature _____*Date* _____