BalanceWorks Massage Center
920 South 107th Ave, Suite #105
Omaha, NE 68114
(402) 933-8133

HEALTH HISTORY

Please Print

Sex: M F

Today's Date: _____ Age: _____

Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (home): _____ (cell): _____ (work): _____

Occupation: _____

Email Address: _____

How did you find us? _____

Please check any of the following conditions that pertain to your health:

- ☐ Neck Conditions
- ☐ Liver Troubles
- ☐ Slipped Disc
- ☐ Painful/Swollen Joints
- ☐ Nerve Disorders
- ☐ Inner Tension
- ☐ Pins/Needles in Arms
- ☐ Headaches
- ☐ Hypoglycemia
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Athletes Foot
- ☐ Cancer
- ☐ Chest Pain
- ☐ Cold Sores
- ☐ Heart Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Fatigue
- ☐ Dizziness
- ☐ Varicose
- ☐ Migraines
- ☐ Tightness in Shoulders
- ☐ Cold Sweats
- ☐ Epilepsy
- ☐ Skin Trouble
- ☐ Gall Bladder Trouble
- ☐ Pneumonia
- ☐ Thyroid Trouble
- ☐ Sleeping Problems
- ☐ Blood Clots
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Fibromalgia

Please list any serious illness not listed above: _____

List medications you are currently taking: _____

_____

(over)

Any surgeries (date & type) _____

_____

Complaints: _____

_____

_____

_____

_____

_____

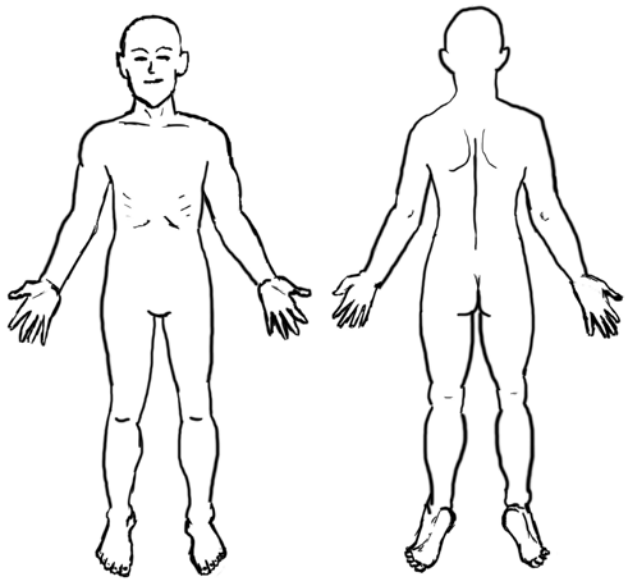
_____

_____

_____

_____

Please indicate any areas of pain:



Are you seeing a physician for this condition?

Yes No

I understand that massage therapy is not intended to be a substitute for medical care. The therapist has not expressed or implied that massage is the primary treatment for any specific illness or disease. I understand that massage is adjunctive therapy that can be coordinated with any advice, treatment or prescriptions recommended by my regular physician. The decision to follow or reject a series of therapies is left to my own discretion. It is also understood 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 for the full scheduled appointment.

Please complete this health history as fully as you can. Your signature validates the above information as accurate and reflects your current health status.

Payment is expected at the time of service unless other arrangements have been made.

Note: *A nonrefundable $25 fee will be charged to clients who fail to show up for scheduled appointments.*

Signed_____ Date_____