Balance Massage Therapy | New Client Information Form

Please complete this form and return it to our Front Desk Team. This information will better help us meet your massage and service needs, and ensure your health and wellness. Please let us know if you have any questions about this form. Thank you!

Client Name ________________________________ Birth Date (MM/DD/YYYY) ____________________

Current Address ____

City ___________________________ State _____________________ ZIP Code _______________

Cell Phone # ____________________ Home # _____________________ Work #____________________

Email Address ____ Occupation ____________________

Emergency Contact Information

Name ______________________ Relationship to You ___________________ Phone # __________________

How did you learn about Balance?

- ☐ Internet Search
- ☐ Location/Drive By
- ☐ Yelp
- ☐ Word of Mouth
- ☐ Gift Certificate
- ☐ Facebook
- ☐ Physician Referral
- ☐ The Ann Arbor Observer
- ☐ Moonwinks Cafe
- ☐ Natural Awakenings
- ☐ Expo/Fair/Event
- ☐ Physical Therapy | Company Name: ____________________________
- ☐ Another Client: ____________________________
- ☐ Other ______________________

Have you received massage therapy before?

☐ NO ☐ YES: What kind? ______________________________ How often? ____________________

If you are experiencing pain today, please specify the level and location on the scale below:

Mild 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe Location ______________________________

Please review and initial the following information about Balance’s 24-hour cancellation policy.

Balance’s cancellation policy helps ensure that therapists' investment in their time is acknowledged & recognized.

__________ I agree to cancel my appointment at least 24 hours in advance by phone unless I have an emergency or illness. In this case, I will call Balance as soon as possible to cancel or reschedule my appointment.

__________ If I arrive late, I agree to pay the full session price, regardless of how much time is left of the scheduled appointment.

__________ I authorize Balance Massage Therapy to charge my credit card the applicable Late Cancel or No Show Fee for any late cancelled or missed appointments. The fee is $1 per minute for length of your scheduled massage. Ex: 60 Min massage = $60 Late Cancel/No Show fee

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Have you experienced or are you currently experiencing any of the following? Please check all that apply and include any additional information where indicated.

Chronic Illness

- ☐ Diabetes
- ☐ Arthritis
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Osteoporosis
- ☐ Cancer

What Kind? ________________

Are you currently undergoing chemotherapy?
☐ YES ☐ NO

Other: ___________________

- ☐ Sensitivity to Touch/Pressure
- ☐ Tension or Soreness
- ☐ Stress

Allergies

- ☐ Nut Oils
- ☐ Latex

Other:
____

Injuries

- ☐ Muscle Sprain/Strain
- ☐ Broken Bones

Which Ones? __________________

How Long Ago? ________________

- ☐ Chronic Back or Neck Pain

Cardiac/Circulatory Problems

- ☐ Blood Clots
- ☐ Varicose Veins
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Hyperglycemia

Other

- ☐ Numbness

Where? _______________________

- ☐ Migraines
- ☐ Surgery

What Kind? ___________________

How Long Ago? _______________

Please specify which prescription medication(s) you are currently taking, if any:

____

Please complete this section only if you are currently pregnant.

Number of weeks along: _______________________ Due date (MM/DD/YYYY): _____________________________

Do you have any pregnancy-specific conditions or complications? If so, please specify:

Carefully read the following information and sign where indicated.

I have completed this health form to the best of my knowledge. I understand that Balance Massage Therapy services are a therapeutic health aid and are non-sexual. Massage services do not take the place of a physician's care when indicated. Any information exchanged during a massage session is confidential and is only used to provide you with the best health care services. I understand that BMT is not responsible for lost or damaged personal items.

Signature ____ Date _____________________

Consent to treatment of a minor. By my signature below, I authorize Balance Massage Therapy to administer massage therapy to my child or dependent as they deem necessary.

Name of Child ___________________________ Signature of Parent/Guardian _________________________________