Back in Balance
THERAPEUTIC MASSAGE

PERSONAL INFORMATION

Name: _____
First M.I. Last

Address:_____

_____

Email: _____

Referred by: _____

Emergency contact name (relationship): _____

Emergency contact #:_____

Primary MD_____Orthopedic: _____

Chiropractor: _____

MASSAGE PREFERENCES

Have you had a professional massage before? ☐Yes ☐ No

What type of pressure do you prefer?

☐ Light ☐ Moderate ☐ Deep ☐ Not sure

How long have you been receiving massage therapy?: _____

Frequency of massages?: _____

Any areas you'd not want to be massaged? _____

CURRENT HEALTH

Reason for initial visit: _____

_____

What are your expectations/goals for this session?

☐ Relaxation/Stress relief ☐ Stimulate/Increase energy

☐ Injury/Chronic Pain ☐ Flexibility/Posture Training

Do you exercise regularly and/or participate in any sports? ☐Yes ☐ No

If yes, what kind?: _____

Do you perform any repetitive movement in your work, sports or hobby? ☐Yes ☐ No

If yes, describe:_____

Do you sit for long hours at a workstation, computer, or driving? ☐Yes ☐ No

If yes, describe: _____

Do you experience stress at work or in your personal life? ☐Yes ☐ No

Are you experiencing tension, stiffness, discomfort or pain? ☐Yes ☐ No

If yes, describe: _____

Have you recently had an injury, surgery or areas of inflammation? ☐Yes ☐ No

If yes, describe:_____

_____

Do you have sensitive skin? ☐Yes ☐ No

Do you have any allergies to oils, lotions or fragrances? ☐Yes ☐ No

MEDICATIONS:	**REASON:**	**ALLEGIES**:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DO YOU HAVE ANY OF THE FOLLOWING TODAY?

☐ Sunburn ☐ Inflammation ☐ Severe Pain

☐ Cold/Flu* ☐ Skin Rash ☐ Strains/Sprains

☐ Open cuts, Bruises, Burns

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

CHECK ALL THAT APPLY

CIRCULATORY

☐ Heart Condition ☐ Phlebitis/Varicose Veins

☐ Blood Clots ☐ High/Low Blood Pressure

☐ Lymphedema ☐ Thrombosis/Embolism

RESPIRATORY

☐ Breathing Difficulty/Asthma ☐ Emphysema

☐ Allergies, specify: ☐ Sinus Problems

NERVOUS SYSTEM

☐ Shingles ☐ Numbness/Tingling

☐Pinched Nerve ☐ Chronic Pain

☐ Paralysis ☐ Multiple Sclerosis

☐ Parkinson's Disease

REPRODUCTIVE

☐ Pregnant, week___ ☐ Prostate issues

☐ Ovarian/Menstrual Problems

SKIN

☐ Allergies, specify: ☐ Rashes

☐ Cosmetic Surgery ☐ Athlete's Foot

☐ Herpes/Cold Sores

DIGESTIVE

☐ Irritable Bowel Syndrome ☐ Bladder/Kidney Ailment

☐ Colitis ☐ Crohn's Disease

☐ Ulcers

PSYCHOLOGICAL

☐ Anxiety/Stress Syndrome ☐ Depression

OTHER

☐ Cancer/Tumors ☐ Diabetes

☐ Drug/Alcohol/Tobacco Use ☐ Contact Lenses

☐ Dentures ☐ Hearing Aids

☐ Any other medical condition(s) not listed

Please Explain any of the conditions you have marked above:

_____

_____

_____

COLD/FLU/VIRUS INFORMATION*:

Have you had a fever in the last 24 hours?

☐Yes ☐ No

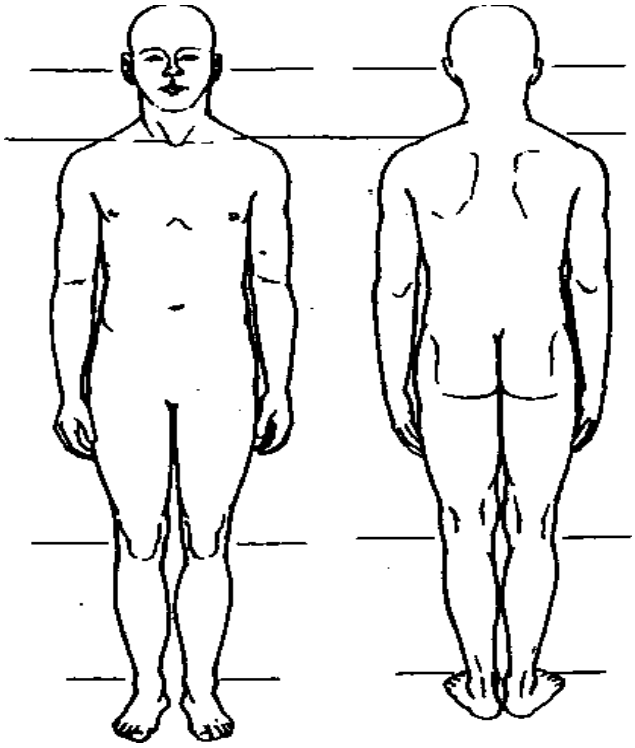
Do you now, or recently had any respiratory or flu symptoms, sore throat, new loss of taste/smell, repeated chills, nausea/vomiting headache or shortness of breath?

☐Yes ☐ No

Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or coronavirus-type symptoms?

☐Yes ☐ No

PLEASE INDICATE AREAS YOU FEEL DISCOMFORT/PAIN:



CLIENT AGREEMENT

It is my choice to receive massage therapy.

I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or a diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that all information will be kept confidential unless required by law.

Signature: _____Date: _____

INFORMED CONSENT

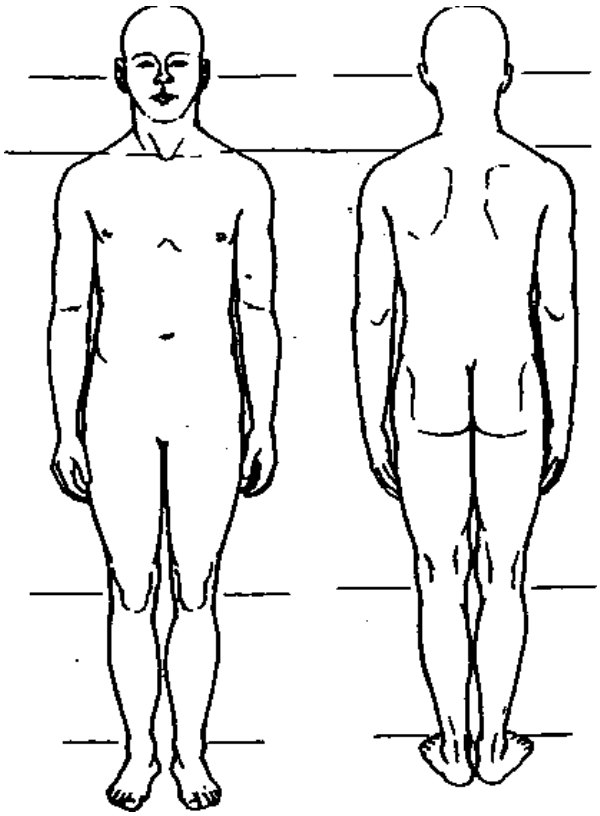
I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period, there may be an elevated risk of disease transmission, including but not limited to COVID-19 (SARS-COV2). I am aware that all staff at BIBTM are following the guidelines established by the CDC, State/local authorities, and their professional massage organizations. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage and bodywork from the practitioners at Back in Balance Therapeutic Massage, LLC and release them of any liability due to possible infection.

Signature: _____ Date:_____

Therapist
Signature: _____ Date:_____

THERAPIST USE ONLY: Tx Length:_____

Focus for today, Symptoms: Location/Intensity/Frequency/Duration/Onset/What makes the pain better/worse?



Findings: Visual/Palpable/AROM/PROM/AAROM/Resisted ROM/Postural Distortions
___EFF___PET___MFR___XFF_____TP___MET____AIS___CUPPING
___LF___PELVIC STAB KT

Prioritize Functional Limitations/Response to Tx/Reassess of ROM's

Future Treatments/Frequency/Homework/Self-care

Therapist's Signature:_____Date: _____

Initials:

☐ Pre Tx Screening Process Completed prior to entry in Tx areas _____
☐ Post Tx Sanitation Protocol Completed _____

Therapists: This form **MUST** be completed and filed correctly before you leave for the day. No Exceptions