



Health Information and Client Consent Form
For Massage Therapy Treatments at
Natural Balance Massage & Wellness, LLC.

Name: _____ Birth date: _____

Address: _____ Telephone: _____

Email: _____ Age: _____ Gender: _____

Occupation: _____

Name of Primary Healthcare Provider: _____

Emergency Contact:

Name: _____ Relationship: _____

Telephone: _____

Notifications:

Would you like to receive text or email reminders for your appointments?

Yes ____ No ____

If yes, what kind of notifications would you like to receive?

Text ____ Email ____ Both ____

Please check the following conditions if they apply to you:

_____ Skin condition (acne, rashes, allergies, bruising or any contagious condition)

_____ Allergies

_____ Recent Injuries or surgery

_____ Tension or cramping of the muscles

_____ Arthritis/ osteoporosis

_____ Swollen glands/ lymphoma

_____ Varicose veins

_____ High or low blood pressure

_____ Heart disease or recent heart attack

_____ Numbness or tingling in any area of the body

_____ Epilepsy

_____ Multiple Sclerosis

_____ Spinal injuries

_____ Headaches

_____ Cancer

_____ Depression

_____ Anxiety

_____ Panic attacks

_____ Diabetes

_____ Back pain

Please circle yes or no for the following questions as it pertains to you:

- | | | |
|---|-----|----|
| • Have you ever had a professional massage before? | Yes | No |
| • Do you have any allergies or sensitivities to oils, lotions, or any fragrances that may be used on your skin? | Yes | No |
| • Do you wear contact lenses? | Yes | No |
| • Do you wear a hearing aid? | Yes | No |
| • Do you have dentures? | Yes | No |
| • Are you pregnant? | Yes | No |

Is there anything else you think should be considered for your massage therapist to administer a safe and effective massage for you?

I understand the purpose of the massage sessions are for general wellness and I should consult a physician or other healthcare provider for diagnosis and treatment of any possible medical problems.

I also understand that it is my responsibility to keep my massage practitioner informed of any changes in my health and medications.

Signature: _____ Date: _____

Signature of parent/guardian if client is under 18:

_____ Date: _____