

OPTIMAL BALANCE THERAPEUTIC MASSAGE LLC

Health and Personal Information

For the safety of your session, please fill out this confidential questionnaire. Thank You!

Name: _____ Date: _____

Address: _____ Referred By: _____

Home Phone: _____ Cell: _____

If you would like specials please provide E-mail: _____

Emergency Contact & Phone: _____

Primary Care Physician: _____

List any medications currently taking: _____

Are you under medical supervision? Yes No

If Yes Please Explain: _____

Expectations for today's Massage Session: (Relaxation, Stress Reduction,
Pain Reduction, Release Muscle Tension)

Are you receiving any other treatments? (Physical therapy, Chiropractic, etc)

If injury when did it occur or onset of complaint? _____

Any allergies to oils or lotions? Yes No

I understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion and improve circulation. I know that massage therapist do not diagnose illness or that massage therapy is not a substitute for medical treatment. I will inform the massage therapist of all my known physical conditions and medications and will update any changes in my health.

Signature _____ Date _____