Back To
BALANCE
MASSAGE & WELLNESS LLC

Name:_____
Address:_____
Phone: (1)_____(2)_____
E-mail: _____

Circle the *reason for your appointment* today: **Massage Therapy** / **Wellness Services** / **Both**

- What is your **major complaint** or issue_____

HEALTH HISTORY

1. Are you presently under the care of a medical doctor? No / Yes For:_____
2. What are your main sources of stress?_____
3. Please check the following conditions that apply to you **past** or **present**. Then **add dates** + your **comments** to clarify.

MUSCULO-SKELETAL
- o HEADACHES
- o JOINT STIFFNESS /SWELLING / PAIN
- o SPASMS / CRAMPS
- o BROKEN / FRACTURED BONES
- o STRAINS / SPRAINS
- o BACK / HIP PAIN
- o SHOULDER, NECK PAIN
- o ARM, HAND PAIN
- o LEG, FOOT PAIN
- o CHEST, RIBS, ABDOMINAL PAIN
- o PROBLEMS WALKING
- o JAW PAIN / TMJ
- o TENDONITIS
- o BURSITIS
- o ARTHRITIS
- o OSTEOPOROSIS
- o SCOLIOSIS

CIRCULATORY AND RESPIRATORY
- o DIZZINESS
- o SHORTNESS OF BREATH / ASTHMA
- o FAINTING
- o COLD FEET OR HANDS
- o COLD SWEATS
- o SWOLLEN ANKLES
- o VARICOSE VEINS
- o BLOOD CLOTS
- o STROKE
- o HEART CONDITION
- o SINUS PROBLEMS
- o HIGH / LOW BLOOD PRESSURE
- o LYMPHEDEMA

SKIN
- o RASHES / DRY / ITCHY
- o ATHLETES'S FOOT
- o WARTS
- o MOLES
- o ACNE

DIGESTIVE
- o NERVOUS STOMACH
- o INDIGESTION / GAS / BLOATING
- o CONSTIPATION/BOWEL ISSUES
- o CRAVINGS _____
- o DIARRHEA / LOOSE STOOLS
- o DIVERTICULITIS
- o IRRITABLE BOWEL SYNDROME (IBS)
- o CROHN'S DISEASE
- o COLITIS
- o ALLERGIES / SENSITIVITY_____
- o STOMACH PROBLEMS IN GENERAL

NERVOUS SYSTEM
- o NUMBNESS/TINGLING/TWITCHING
- o FATIGUE/LACK OF ENERGY
- o CHRONIC PAIN / NEUROPATHY
- o SLEEP DISORDERS
- o ULCERS
- o PARALYSIS
- o HERPES/SHINGLES
- o CEREBRAL PALSY
- o EPILEPSY
- o CHRONIC FATIGUE SYNDROME(CFS)
- o MULTIPLE SCLEROSIS (MS)
- o PARKINSON'S DISEASE
- o SPINAL CORD INJURY

REPRODUCTIVE SYSTEM
- o PREGNANCY_____PAST _____CURRENT
- o PMS
- o MENOPAUSE
- o PELVIC INFLAMMATORY DISEASE
- o ENDOMETRIOSIS
- o HYSTERECTOMY
- o FERTILITY CONCERNS
- o PROSTRATE PROBLEMS

OTHER
- o FORGETFULNESS/CONFUSION
- o DEPRESSION
- o DIFFICULTY CONCENTRATING/FOCUS
- o DRUG USE PRESENT OR PAST
- o ALCOHOL / NICOTINE / CAFFEINE USE
- o HEARING / VISUALLY IMPAIRED
- o BLADDER INFECTION
- o KIDNEY / LIVER ISSUES
- o ENERGY LEVEL: GOOD OK POOR
- o SLEEP ISSUES
- o WEIGHT ISSUES
- o EATING DISORDER
- o DIABETES 1 OR 2
- o THYROID CONCERNS
- o FIBROMYALGIA
- o CANCER / HEPATITIS / AIDS
- o VIRAL / BACTERIAL INF **(LIST BELOW)**
- o INFECTIOUS DISEASE **(LIST BELOW)**
- o **SURGERIES**_____
  _____
  _____
  _____

Please list additional comments regarding your health and well being that I should be aware of:

NUTRITIONAL ANALYSIS

1. Please list any medications, nutritional supplements, herbs, vitamins **currently on** :_____
   _____
2. Give a brief description of a typical day of eating for you:_____
   _____
3. Do you eat fast food more than 1x a week? _____ About how many times per month?_____
4. What **%** of your food is organic? _____ Processed? _____ Genetically Modified? _____ Microwaved_____
5. Do you use artificial sweeteners? _____ Diet foods? _____ Light foods? _____
6. How many 8oz servings do you drink a day: **Coffee**_____ **Tea**_____ **Energy/Sports drinks** _____ **Soda**_____
   Juice_____ **Water**_____ is it…*Tap / Reverse Osmosis / Filtered* **Alcohol**_____ daily _____weekly
7. Do you detox regularly? _____ How often? _____ Type of detox?_____
8. Do you exercise weekly? _____ Type_____ How long_____

The views and educational information expressed by Sara laux, Back To Balance LLC, Back To Balance Massage & Wellness are not intended to be a substitute for medical advice. nor do we intend to diagnose or treat any disease. We offer MassageTherapy & Wellness Services designed to educate and help you in your journey towards balanced health. We provide our services to you with reasonable care and skill. I encourage you to make your own health care decisions based upon your own research and in partnership with a qualified health care professional.

Client's Signature:_____ Date:_____

262-573-9594
www.thejourneytobalance.com

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Name:_____
Address:_____
Phone: (1)_____(2)_____
E-mail: _____

GOALS

On a scale of 1 - 10 (with 10 being the greatest)

Rate your **current level** of:

- ❖ Overall Health _____ Explain_____
- ❖ Overall Energy _____ Explain_____
- ❖ Overall Stress _____ Explain_____

Rate your **desired goa**l for:

- ❖ Overall Health _____ Explain_____
- ❖ Overall Energy _____ Explain_____
- ❖ Overall Stress _____ Explain_____

1. Have you ever had any traumas in your life, physical, mental, emotional or spiritual? NO / YES
   Do you feel open to sharing? _____
2. What is your highest value in life? _____
3. What **benefits** do you desire to experience? (mark all that apply) **List your top 3**

○ Increased Energy	○ Detoxification	○ Mental Clarity	○ Better Sleep
○ Weight Management	○ Hormone Balance	○ Feel better overall	○ Less Stress
○ Pain Management	○ Improved Digestion	○ Reduce cravings	○ Balanced Moods
○ Reduce/Eliminate Symptoms	○ Other_____	○ Other_____	○ Other_____

WELLNESS COMMITMENT

The best results of any program come from those who are committed. O**n a scale 1 – 10** (with 10 being the most committed)

- ❖ How strong is your desire to experience beneficial results? _____
- ❖ **How committed are you** when it comes to your health and the process it takes to make improvements? _____
  Do you have any reservations (if so, what are they)? _____

Along with commitment, a **positive support group** is incredibly important for successful follow thru.
List 3 positive people in your circle of support?

1. _____
2. _____
3. _____

As your practitioner, how can I best support you? _____
_____

PERSONAL COMMITMENT

I acknowledge my readiness and willingness, and commit 100% of my effort, both in thoughts and actions, to the process of being WELL.

_____ _____ _____
Name (print) (Sign) Date

Thank you for choosing
Back To BALANCE
MASSAGE & WELLNESS
as part of your journey towards balanced health!

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