Back To BALANCE MASSAGE & WELLNESS

Name:____

Address:____

Phone: (1)_______________________ (2)_____________________

E-mail Opt In/Newsletter: __________________________________

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

- **Major complaint** or issue ____

HEALTH HISTORY

1. Are you presently under the care of a medical doctor? No / Yes For:______________________
2. Main sources of stress? ____

Please check the following conditions that apply to you **past** or **present**. Then **add dates** + **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 / FAINTING
- o SHORTNESS OF BREATH / ASTHMA
- 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 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
- 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**_________________________

____

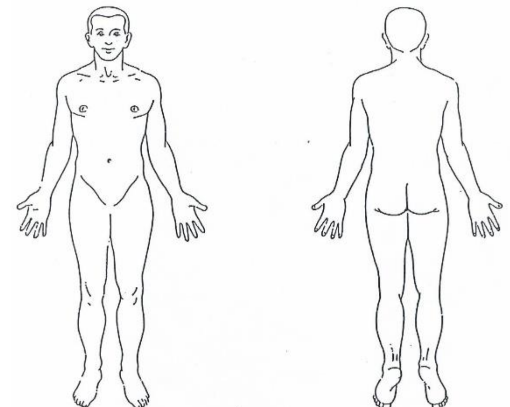
____

____

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

MASSAGE THERAPY

1. When was the last time you had a massage? ______________________________
2. Are you under the care of a Chiropractor? _______________________________
3. Using the diagram to the right, please circle your areas of concern.
4. Have you had any x-rays or an MRI of the area of concern? _________________



With any modality, results may take time. I see a benefit from a combination of therapies & treatments with progress often made from work that you do at home. Therefore, on occasion , I give homework for you to implement between sessions. Your follow thru and involvement in treatment is important.

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 Massage Therapy & 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

Back To Balance LLC

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WELLNESS SERVICES: NUTRITIONAL ANALYSIS

1. Please list any medications, supplements, herbs, vitamins **currently on (Provide separate sheet if needed)**: ______________________
____
2. Give a brief description of a typical day of eating for you:
____
3. Do you eat fast food more than 1x a week? ________________ 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**________ *(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____________________

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
   Please share if you are open to it ______________ ______________________________________
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 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 & willingness, to **commit 100%** of my effort. in thoughts & 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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Back To Balance LLC