Confidential Case History

Back in Balance
Jodie Noll, LMT (716) 307-3943

Name: _____ Date of Birth ____/____/____Today's Date ___/___/___

Male Female If female, are you pregnant? Yes No Maybe If yes, how many weeks?_____

Address:_____City_____

State:_____Zip:_____ Occupation:_____

Phone(day):_____(eve)_____(cell)_____

1. Please indicate by circling the following conditions you may have or have had.

Aneurysm Arteriosclerosis Cancer Diabetes Heart Disease

High Blood Pressure MS Poor Circulation Stroke Osteoporosis Fibromyalgia

Chronic Fatigue Syndrome Arthritis Allergies Other_____

*******Please let us know of any nut allergies as many lubricants are nut based*******
*****If you have HIV/ AIDS we would appreciate you letting us know for your own safety!*****

2. Major Complaints:_____

3.Hasthere been a medical diagnosis?_____If yes, by whom?_____

4.How long have you had this condition?_____

5.Have you had similar conditions in the past? If yes, describe:_____

6. What activities aggravate your condition?_____

7. Is the condition getting progressively worse? Y N Constant? Y N Sporadic? Y N

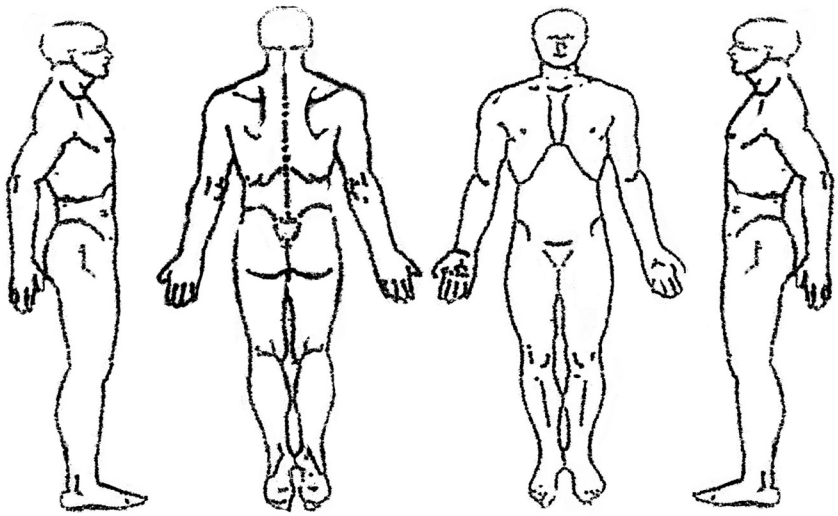
8. Is the condition interfering with: Work Sleep Daily routine ?

9.List any surgical operations or significant injuries and dates:_____
_____

10.Please list any prescription drugs that you are taking:_____
_____

11.Wheredid you hear of our services?_____

Please indicate on the image below where you would like work done.



I have been advised that it will be beneficial to urinate prior to a massage and it is perfectly normal to feel a need to urinate immediately after a massage. It is extremely important to drink plenty of water for a period of 24-48 hours after having a massage.

Because a massage therapist must be aware of any existing medical conditions that I have, I have listed all of my known medical conditions and physical limitations, and I will inform my massage therapist of any changes in my physical health.

I understand that, if I have a specific medical condition or specific symptoms, a written referral from my primary care provider may be requested prior to treatment. I know that Back in Balance reserves the right to discontinue treatment according to medical conditions, noncompliance with ethical codes, or sexual misconduct.

I agree to pay for all services at the time they are rendered unless prior arrangements have been made.

Signature:_____Date_____