Natural Balance Therapeutic Massage *Therapist: J. Tomas Parrales, LMT*

Date: _____ Referred by: _____

Name: _____ Date of Birth: _____

Address: _____

Phone: Work: _____ Home: _____ Cell: _____ Email: _____

Contact Person (in case of emergency): _____ Phone: _____

Occupation: _____ Special Interests/Exercise: _____

What posture are you in most of the day? _____

Where do you carry tension? _____

Do you often interact with young children? _____ Describe: _____

Do you wear glasses or contacts? _____

Are you experiencing (have you experienced) any of the following symptoms or problems? List current medications.

Allergies: _____

Arthritis (Where?): _____

Diabetes: _____

Epilepsy (Meds): _____

Headaches/Migraines (Frequency): _____

Heart (Details): _____

Hearing (Hearing Aids): _____

High/Low Blood Pressure (Meds): _____

Joint Replacements (Where): _____

Low Back Pain: _____

Multiple Sclerosis: _____

Neck Pain: _____

Respiratory/Lung: _____

Sciatica: _____

Scoliosis: _____

Skin: _____

Other: _____

_____

_____

Are you pregnant? _____ Due Date: _____

Have you ever had any bones broken? _____ Describe including date(s): _____

_____

Have you ever had any operations? _____ Describe including date(s): _____

_____

Have you ever been in any accidents? _____ Describe including date(s): _____

_____

Are you presently receiving medical/therapeutic care? _____ If so, for what condition? _____

_____

Name of Doctor(s), Office Location: _____

Do I have your permission to call your Doctor(s) should that be necessary? _____

Is there anything else you would like for me to be aware of regarding your well-being? _____

_____

Signature: _____