BODY-N-BALANCE

3005 Old Alabama Road, Building E, Johns Creek, Georgia 30022
T 770.552.8852 F 770.552.8481
www.body-n-balance.com

STUDIO QUESTIONNAIRE

NAME: _____ **BIRTHDATE:** _____
LAST FIRST MIDDLE INITIAL

How did you hear about us? _____

What benefits would you like to receive? _____

List your current physical activities: _____

List any past or present injuries: _____

Have you received any treatment for the problem? (circle one) Yes No

If yes, what type of treatment? _____

List any prescription medication, over the counter medication, vitamins, or supplements that you are presently

Are you allergic to any medications? (circle one) Yes No

If yes, please list those medications: _____

List type and date of any previous surgery: _____

Do you have any metal implants or pins? (circle one) Yes No

Have you had any unexplained weight gain or weight loss in the past month: (circle one) Yes No

Do you smoke? Yes No If yes, _____ How many years? _____

Do you drink alchohol?(circle on Yes No

How much caffeine do you consume a day (coffee, tea, softdrinks, etc)? _____

Females Only: Are you pregnant or is there any possibility that you might be pregnant? Yes No

Have you ever been diagnosed with?

Cancer Type: _____	Yes	_____	No	_____
Heart Problems:				
High Blood Pressure	Yes	_____	No	_____
Coronary Heart Disease	Yes	_____	No	_____
Heart Attack	Yes	_____	No	_____
Congestive Heart Failure	Yes	_____	No	_____
Peripheral Vascular Disease	Yes	_____	No	_____
Thrombophlebitis	Yes	_____	No	_____
Pace Maker	Yes	_____	No	_____
Respiratory Problems:				
Asthma	Yes	_____	No	_____
Emphysema	Yes	_____	No	_____
Chronic Bronchitis	Yes	_____	No	_____
Rheumatoid	Yes	_____	No	_____
Other: _____	Yes	_____	No	_____
Osteoporosis	Yes	_____	No	_____
Stroke	Yes	_____	No	_____

Have you ever been diagnosed with?

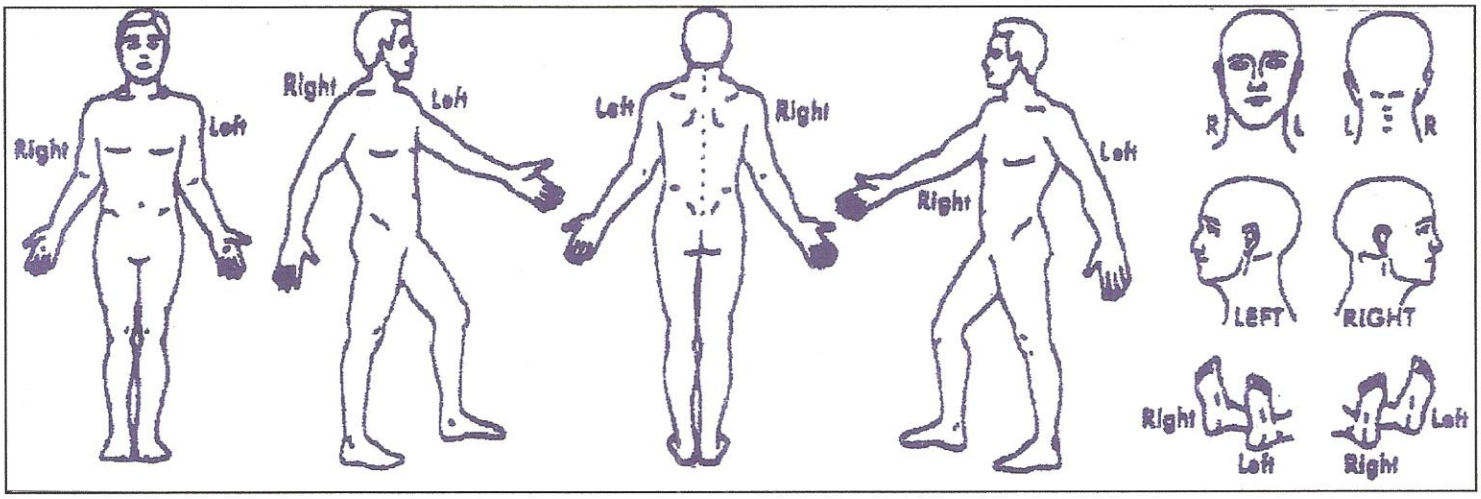
Diabetes	Yes	_____	No	_____
Anemia	Yes	_____	No	_____
Multiple Sclerosis	Yes	_____	No	_____
Kidney/Bladder Problems	Yes	_____	No	_____
Epilepsy	Yes	_____	No	_____
Chemical Dependency	Yes	_____	No	_____
Depression	Yes	_____	No	_____
Migraine Headaches	Yes	_____	No	_____

Other (please list): _____

For Massage Therapy Clients Only:

List areas of the body you would like worked on: _____

List areas of the body you do not want worked on: _____



SHADE AREAS WHERE YOU EXPERIENCE TIGHTNESS

PLACE AN "X" MARK ON AREAS WHERE YOU EXPERIENCE PAIN

THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE AND I UNDERSTAND THAT IT WILL REMAIN CONFIDENTIAL.

_____ _____ _____

Signature Date