being balanced
Bodywork at Stillwaters

HEALTH INFORMATION

Client Name: _____ Today's Date: _____

Date of Birth: _____ Preferred Method(s) for Contacting: ☐ Phone ☐ Email ☐ Text

Client Information

Address _____

City/State/Zip_____

Phone(s)

Home _____

Work _____

Cell _____

Best number to reach you/ leave message _____

Email _____

May we add you to our mailing list? (we never sell information)

☐ Yes ☐ No

Occupation _____

Emergency Contact _____

Phone _____

Primary Health Care Provider

Name _____

Address _____

City/State/Zip _____

Phone _____

Current Health Concerns

Primary _____

Secondary _____

Additional _____

_____

_____

Goals

What are your goals for health, and how may I assist you in in achieving your goals?

_____

_____

_____

List Daily Activities Limited by Condition(s)

At work_____

_____

Home/Family_____

_____

Sleep/Self-Care _____

_____

Social/Recreational _____

_____

List Self-Care Routine

How do you reduce stress? _____

_____

Do you engage in any exercise?

☐ Yes ☐ No

If yes, what? _____

_____

Frequency _____

List current medications (include pain relievers & supplements) _____

_____

_____

_____

Heath History

List and Explain. Include dates and treatments received.

Surgeries _____

_____

_____

Injuries _____

_____

_____

Major Illnesses _____

_____

_____

_____

Contact Info: (336)327-6431 • lizzie@beingbalanced.net • @Stillwaters 5902 Stoneleigh Pl. Greensboro, NC 27455

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HEALTH INFORMATION page2

Check All Current and Previous Conditions

General

current	past	
☐	☐	headaches
☐	☐	pain
☐	☐	sleep disturbance
☐	☐	fatigue
☐	☐	infections
☐	☐	fever
☐	☐	sinus
☐	☐	other _____

Skin Conditions

current	past	
☐	☐	rashes
☐	☐	athlete's foot/ warts
☐	☐	skin allergies
☐	☐	other_____

Nervous System

current	past	
☐	☐	head injuries
☐	☐	dizziness, tinnitus
☐	☐	loss of memory or confusion
☐	☐	numbness, tingling
☐	☐	sciatica
☐	☐	shooting pain
☐	☐	chronic pain
☐	☐	Multiple Sclerosis
☐	☐	Muscular Dystrophy
☐	☐	Parkinson's
☐	☐	other_____

Endocrine System

current	past	
☐	☐	thyroid
☐	☐	diabetes
☐	☐	other_____

Muscles, Bones and Joints

current	past	
☐	☐	rheumatoid arthritis
☐	☐	osteoarthritis
☐	☐	scoliosis
☐	☐	broken bones
☐	☐	spinal problems
☐	☐	disc problems
☐	☐	lupus
☐	☐	TMJ, jaw pain
☐	☐	spasms, cramps
☐	☐	sprains, strains
☐	☐	tendonitis, bursitis
☐	☐	stiff or painful joints
☐	☐	weak or sore muscles
☐	☐	neck, shoulder pain
☐	☐	arm, hand pain
☐	☐	upper back pain
☐	☐	lower back pain
☐	☐	hip, leg pain
☐	☐	other _____

Digestive System

current	past	
☐	☐	bowel problems
☐	☐	gas, bloating
☐	☐	bladder/kidney/ prostate
☐	☐	abdominal pain
☐	☐	other_____

Reproductive System

current	past	
☐	☐	pregnancy
☐	☐	PMS
☐	☐	fibrotic cysts
☐	☐	other _____

Respiratory and Cardiovascular

current	past	
☐	☐	heart problems
☐	☐	blood clots
☐	☐	stroke
☐	☐	lymphedema
☐	☐	high or low blood pressure
☐	☐	irregular heart beat
☐	☐	poor circulation
☐	☐	swollen ankles
☐	☐	varicose veins
☐	☐	chest pain
☐	☐	shortness of breath
☐	☐	asthma
☐	☐	other _____

Cancer/Tumors

current	past	
☐	☐	type_____
☐	☐	benign tumors
☐	☐	other _____

Other

current	past	
☐	☐	Fibromyalgia
☐	☐	depression
☐	☐	implants
☐	☐	hearing impaired
☐	☐	visually impaired
☐	☐	other _____

Habits

current	past	
☐	☐	tobacco _____
☐	☐	alcohol_____
☐	☐	drugs_____
☐	☐	coffee/soda_____
☐	☐	other _____

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