- CONFIDENTIAL -

Health History Form

Name: _____ DOB: _____

Address: _____ Emergency Contact: _____

City/State/Zip: _____ Em Contact Phone: _____

Email: _____ Primary Physician: _____

Phone: _____

Accept/Prefer Text Messages? ☐ Yes ☐ No

Occupation/Employer: _____

How did you hear about Sara J. McRae, LMT? ☐ word of mouth ☐ Facebook ☐ other _____

Referrals are Rewarded! Referred By: _____

TREATMENT INFORMATION

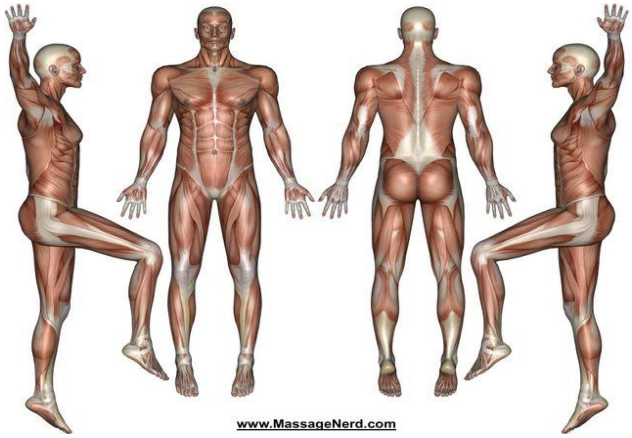
When was your last professional massage or bodywork session? _____

What level of pressure do you prefer? ☐ light ☐ medium ☐ firm

Circle the areas of your body that you give permission to receive massage:

back legs buttocks arms abdomen chest neck head face feet

Circle the areas of your body that you are currently experiencing pain, tension, or reduced range of motion:



Please prioritize the areas of your body that you would prefer to receive treatment:

_____

What results do you want from your massage? (Please list any bodywork goals or expectations)

_____

HEALTH HISTORY

Please take a moment to carefully read the following information. If you have a specific medical condition or symptoms, massage may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Are you currently seeing a medical practitioner? ☐ Yes ☐ No

If yes, please explain your health concerns: _____

How would you rate your overall health? ☐ excellent ☐ good ☐ fair ☐ poor

What physical activities or exercise(s) do you regularly participate in?

_____

If you answer "yes" to any of the following questions or conditions, please explain as clearly as possible.

☐ Yes ☐ No Any recent illness or fever? _____

☐ Yes ☐ No Any injuries or surgeries in the past two years? _____

☐ Yes ☐ No Any broken or fractured bones in the past two years? _____

☐ Yes ☐ No Are you taking any medications? _____

☐ Yes ☐ No Regular use of alcohol/nicotine/caffeine/other? _____

☐ Yes ☐ No Do you experience frequent headaches? _____

☐ Yes ☐ No Do you frequently suffer from stress? _____

☐ Yes ☐ No Any bruises, skin allergies, rashes, athletes foot, warts? _____

☐ Yes ☐ No Are you sensitive to touch or pressure in any area? _____

☐ Yes ☐ No Are you Pregnant? _____

MUSCULO-SKELETAL

☐ Yes ☐ No bone or joint disease
☐ Yes ☐ No tendonitis
☐ Yes ☐ No bursitis
☐ Yes ☐ No arthritis
☐ Yes ☐ No sprains/strains
☐ Yes ☐ No sciatica
☐ Yes ☐ No spinal/disc injury or condition
☐ Yes ☐ No low back, hip, leg pain
☐ Yes ☐ No neck, shoulder, arm pain
☐ Yes ☐ No headaches/head injury
☐ Yes ☐ No spasms/cramps
☐ Yes ☐ No jaw pain/TMJ
☐ Yes ☐ No lupus

CIRCULATORY

☐ Yes ☐ No heart condition
☐ Yes ☐ No varicose veins
☐ Yes ☐ No blood clots
☐ Yes ☐ No high/low blood pressure
☐ Yes ☐ No lymphedema
☐ Yes ☐ No asthma, breathing difficulty

☐ Yes ☐ No sinus problems
☐ Yes ☐ No allergies

NERVOUS SYSTEM

☐ Yes ☐ No herpes/shingles
☐ Yes ☐ No numbness/tingling/stabbing pains
☐ Yes ☐ No chronic pain
☐ Yes ☐ No fatigue/sleep disorders

INFECTIOUS DISEASE

☐ Yes ☐ No disease name(s): _____

DIGESTIVE

☐ Yes ☐ No constipation, gas/bloating
☐ Yes ☐ No diverticulitis
☐ Yes ☐ No irritable bowel syndrome

OTHER

☐ Yes ☐ No cancer/tumors or undiagnosed growths
☐ Yes ☐ No diabetes
☐ Yes ☐ No kidney problems
☐ Yes ☐ No seizures/epilepsy
☐ Yes ☐ No eating disorder
☐ Yes ☐ No depression
☐ Yes ☐ No wear contact lenses

Condition Details: _____

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this or any future session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: _____ Date: _____