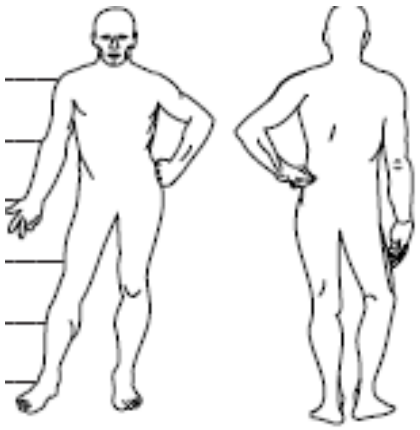
Sarah McMahill, ACMT
Health Information Form

Name: _____ Date of Birth: ____/____/_____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: (home)_____ (work)_____ (cell)_____
Email:_____Referral: _____
Occupation:_____
In case of emergency, please notify:
Name: _____ Telephone #: _____
Relationship: _____
- -
Have you ever had a professional massage before? Y/N
Do you exercise regularly? Y/N
If yes, what types of exercise do you engage in and how often?
_____
Are you currently under the care of a physician, chiropractor or any other medical professional? Y/N
If yes, please describe: _____
Are you currently taking any medication? Y/N
If yes, please identify the medication and for what: _____

Have you had any recent injuries or operations (within one year)? Y/N
If yes, please describe: _____
_____



Please indicate where you have aches, pains, soreness, and/or numbness on the figure at the left.

(OVER)

Health History

Check the following conditions that apply to you, past and present. Please add your comments below to clarify any condition.

AIDS/HIV ☐
Allergies, please specify ☐
_____
Arthritis/Tendonitis ☐
Asthma ☐
Athlete's foot ☐
Back/hip problems ☐
Blood clots ☐
Bruises or Sores ☐
Burns ☐
Bursitis ☐
Cancer or tumors ☐
Chronic Pain ☐
Circulatory problems ☐
Colitis ☐
Constipation ☐
Crohn's Disease ☐
Depression ☐
Diabetes ☐
Diarrhea ☐
Digestive disease, please specify ☐
_____
Drug/Alcohol/Nicotine/Caffeine use, please specify ☐
_____
Eczema ☐
Epilepsy ☐
Fractures/sprains/strains ☐
Fibromyalgia ☐
Headaches ☐
Hearing Impaired ☐
Heart condition or disease, please specify ☐
_____
Hernia/rupture ☐
Hepatitis ☐
Herpes/Shingles ☐
High/Low Blood Pressure ☐
Hives or shingles ☐
Hysterectomy ☐
Infectious disease ☐
Jaw pain/TMJD ☐
Joint disease/stiffness/swelling ☐
Muscular Injuries ☐
Numbness/Tingling ☐
Open lesions, recent cuts, or infected wounds ☐
Osteoporosis ☐
Paralysis ☐
Parkinson's Disease ☐
Phlebitis/Varicose Veins ☐
PMS ☐
Pregnancy (current or previous) ☐
Prostrate problems ☐
Psoriasis ☐
Rashes ☐
Scoliosis ☐
Sinus problems ☐
Skeletal Injuries ☐
Spinal Cord injury ☐
Skin disease, please specify ☐
_____
STD's ☐
Stroke ☐
Ulcers ☐
Other: ☐
_____
_____
_____
_____

Please clarify any conditions in the space provided below.

_____
_____
_____
_____

I, *(please print)*_____, understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment or pharmaceuticals nor perform any spinal manipulations. It has been made very clear that massage therapy is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment I might have. With this in mind, I agree that the massage therapist cannot be held liable for any problems that might arise as a result of my massage sessions. If I am unable to make an already scheduled appointment, I will notify the massage therapist 24 hours in advance. I agree to pay the full amount of any sessions I miss without notifying the massage therapist. I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Signature: _____

Date: _____/_____/_____