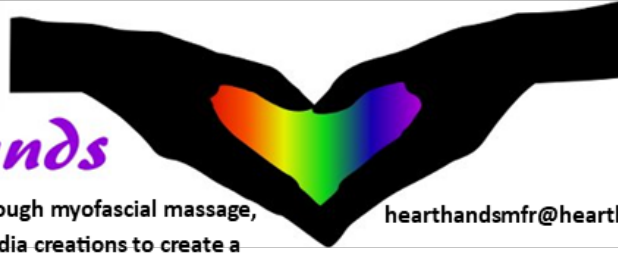


Sarah McMahill  
BCMT, ACMT, ASCAP



*Heart to Hands*



Combining the science and the art of wellness through myofascial massage,  
— enneagram coaching & education, and multi-media creations to create a  
brave space for transformation and healing.

hearhandsmfr@hearhands.net  
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**Contact Information**

The security of your information is important to me. The information you provide will ONLY be for internal marketing and communications.

Name \_\_\_\_\_ Birthday: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Please indicate which method you would like to receive appointment reminders: Text \_\_\_ Email \_\_\_

In case of emergency, please notify:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

**General Information**

Have you ever had a professional massage before? Yes No

The following information tells me how you perceive your health and if there are any areas you would like help with.

Occupation: \_\_\_\_\_

Describe your exercise habits: \_\_\_\_\_

Describe how well you sleep: \_\_\_\_\_

Describe your general health: \_\_\_\_\_

**Health History**

For your safety please be as thorough as possible with this section. This information is important because there are some conditions where massage is not advised or a different technique may need to be utilized.

Describe any surgery or hospitalization:

More than 10 years ago: \_\_\_\_\_

5 to 10 years ago: \_\_\_\_\_

Less than 5 years ago: \_\_\_\_\_

Describe any injuries or accidents:

More than 10 years ago: \_\_\_\_\_

5 to 10 years ago: \_\_\_\_\_

Less than 5 years ago: \_\_\_\_\_

What kind of care did you receive? \_\_\_\_\_

Do you consider that you have recovered from these events? Please explain: \_\_\_\_\_

Do you have any chronic, ongoing conditions that you deal with on a regular basis? Explain. \_\_\_\_\_

Are you taking any medication? Please explain. \_\_\_\_\_

Are you currently seeing a doctor for any reason? Please explain. \_\_\_\_\_

Do you have any skin rashes or other skin problems right now? \_\_\_\_\_

Check off any of the following conditions that you have experienced:

<u>SKIN</u> Boils Fungal Infections Herpes Simplex Warts Eczema Psoriasis Skin Cancer	<u>MUSCULOSKELETAL</u> Fibromyalgia Rheumatoid Arthritis Osteoarthritis TMJ dysfunction Strains, sprains, or tendinitis Carpal tunnel syndrome Thoracic Outlet syndrome	<u>NERVOUS</u> Depression Multiple Sclerosis Post Polio Syndrome Headaches Stroke Seizure disorders Reduced sensation Sleep disorders Chemical dependency	<u>LYMPH/IMMUNE</u> Edema Leukemia/lymphoma HIV/AIDS Chronic Fatigue Syndrome Lupus Other Auto-immune disorders: _____ _____ _____
<u>CIRCULATORY</u> Anemia Thrombophlebitis Deep Vein Thrombosis High Blood Pressure Heart Disease Varicose Veins Clotting disorders	<u>DIGESTIVE</u> GERD (reflux) Ulcers Crohn's Disease Irritable Bowel Syndrome Gallstones Cirrhosis Hepatitis Ulcerative Colitis	<u>REPRODUCTIVE</u> Breast Cancer Endometriosis Ovarian Cysts Prostate Cancer Painful menstruation Are you pregnant? Y/N	
<u>ENDOCRINE</u> Diabetes Hypothyroidism Hyperthyroidism	<u>RESPIRATORY</u> Asthma Emphysema Sinusitis Tuberculosis	<u>URINARY</u> Kidney Stones Renal Failure	

OTHER: \_\_\_\_\_

EXPLANATION: \_\_\_\_\_

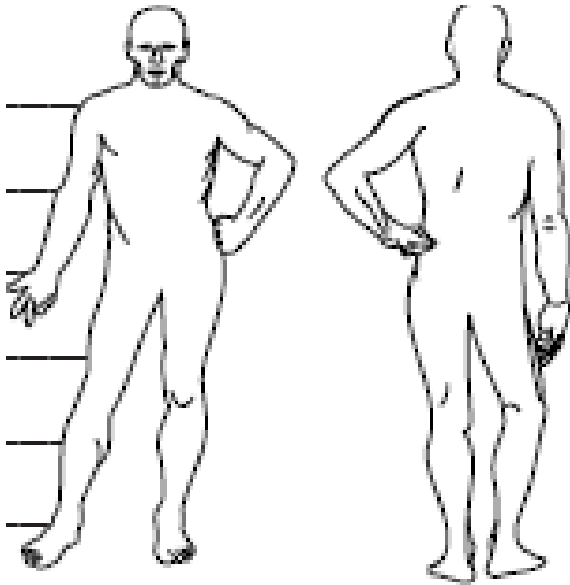
If under the care of a physician: Name \_\_\_\_\_

Phone Number: \_\_\_\_\_ Clinic: \_\_\_\_\_

**Treatment Goals**

Why are you here? What do you hope to accomplish? \_\_\_\_\_

Please indicate where you have pain:



Describe what you do that causes pain, and what activities tend to make it worse: \_\_\_\_\_

\_\_\_\_\_

Are there areas of your body that are off-limits? \_\_\_\_\_

What questions do you have about massage or this massage session? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please use the space below to tell me anything else I need to know or if you need more space to expand on previous questions: \_\_\_\_\_

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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 and half session charge for late cancellation (within 24 hours). 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: \_\_\_\_/\_\_\_\_/\_\_\_\_