Sēva BODYWORK

RESPECT MASSAGE
ZERO TOLERANCE

HEALTH HISTORY

HOW DID YOU HEAR ABOUT US?
Website Facebook Instagram Other: _____
Friend/Referral (we'd like to thank them): _____

PERSONAL INFORMATION:

Name: _____ What are your preferred Pronouns? _____

Email: _____ Phone (home/Cell): _____

Your preferred contact method for appointment reminders: PHONE CALL TEXT EMAIL

Address: _____

City _____ State _____ Zip _____

Date of Birth _____ Occupation _____

MEDICAL/HEALTH INFORMATION:

Emergency Contact _____ Phone _____

1. Have you had a professional massage before? O YES O NO How often: _____
2. *Are you aware of any allergies to oils, lotions, ointments, or scents?* O YES O NO
3. Do you wear: O contact lenses O dentures O hearing aids O hairpiece/extensions
4. Are you pregnant? O YES O NO How many weeks? _____ Due Date: _____
5. Do you have any piercings, implants (pacemaker, contraceptive, metal rods, etc.) or new/recent tattoos?
   O YES O NO When/Location: _____
6. What is your current blood pressure? _____
7. Do you sit for long periods of time at a workstation, computer, or in a vehicle? O YES O NO
8. Have you had *any* surgeries or injuries that could influence today's treatment? O YES O NO

Describe: _____

It's important to that you feel safe and comfortable throughout your massage experience. Providing answers to these next few questions allows me to be sensitive to your story without needing details. If you would prefer to discuss something with me directly instead of writing it down, please check here: _____

9. Are you recovering from addiction? O YES O NO
10. Are you recovering from abuse? O YES O NO
11. If you answered yes to questions #9 or question #10, how do you believe it has impacted your health?
    O Muscle tension O Anxiety O Insomnia O Irritability O Sadness/hopelessness
    Other: _____
12. Are you currently under medical supervision? O YES O NO If yes, please describe: _____
    _____

Please continue on reverse side.

13. Do we have permission to contact your doctor? O YES O NO
14. Healthcare provider: _____ Phone: _____
15. List all current medications & uses, including OTC, supplements and homeopathic herbs, teas, or oils:

    _____

16. Circle Current (C) or Past (P) conditions and provide details below:

C P	Allergies	C P	High | Low Blood Pressure
C P	Arthritis (RA, OA)	C P	Kidney Disease | Kidney Infection
C P	Autism | Asperger's	C P	Multiple Sclerosis
C P	Bleeding Disorder	C P	Muscle or Joint Stiffness, Spasms, or Weakness
C P	Bruise Easily		
C P	Broken Bones	C P	Neuropathy, numbness, tingling
C P	Bursitis	C P	Neuralgia
C P	Cancer	C P	Osteoporosis, Degenerative spine/d
C P	Car Accident (Date: _____)	C P	Sciatica
C P	Depression | Anxiety	C P	Scoliosis
C P	Diabetes (Type: _____)	C P	Seizures
C P	Dizziness, Ringing in ears	C P	TMJ Disorder
C P	Epilepsy, Seizures	C P	Varicose Veins, DVT, Blood Clots
C P	Fibromyalgia	C P	Vertigo, dizziness
C P	Hearing Loss, Tinnitus		

Details for "C" or "P" marks above: _____

_____

17. Skin conditions: O YES O NO _ _____
18. Broken skin? (rash, wound) O YES O NO Where? _____
19. Neurological Conditions: O YES O NO _____
20. Heart Conditions: O YES O NO _____
21. Autoimmune Disorders? O YES O NO _____
22. Digestive Concerns? O YES O NO _____
23. Endocrine Disorder? O YES O NO _____
24. Respiratory Disorder? O YES O NO _____
25. Areas of Swelling? O YES O NO _____
26. Frequent Headaches? O YES O NO _____
27. Areas of numbness|decreased sensation? _____ _____
28. Current infectious|contagious conditions? (HIV, TB, Shingles, Warts, Hepatitis) O YES O NO
    Where? _____
29. Are there other concerns/issues not listed on this form? _____

    _____

30. What are your goals for massage? O Relax O ↓ Pain O ↑ ROM O Other _____

Client Signature: _____ Date: _____

Signature of Parent/Guardian if minor child: _____

The following expressions often occur during massage. These are <u>*normal*</u> responses to relaxation and not cause for concern, alarm, or embarrassment. Trust that your body will express what it needs.

• yawning, sighing or similar changes in breathing • stomach gurgling • emotional feelings/expressions (like tears) • snoring and/or falling asleep • strong memories • movement of intestinal gas • (males) erections • energy shifts • sniffling•

If you need tissues or a short break from treatment, let me know…