McKee Wellness Health History Form

Please print and bring to your 1st appointment, or fill electronically, save, and email to dawn@mckeewellness.com

Client Contact Information

Client Name:		Today's Date:
Date of Birth:	Gender:	
Address:		
City/State/Zip:		
Phone:	Email:	
Referred By:		
Emergency Contact:		Phone:
Physician/Health-care Provider name:		Phone:

Massage Information

Have you ever received professional massage/bodywork before? ◯ Yes ◯ No

How recently:

What types of massage/bodywork do you prefer?

What kind of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

What are your goals/expected outcomes for receiving massage/bodywork?

How do you feel today?

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.)

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? ◯ Yes ◯ No If so explain:

List the medications you currently take:

Are you wearing contacts ◯ Yes ◯ No

Are you wearing dentures ◯ Yes ◯ No

Are you wearing a hairpiece ◯ Yes ◯ No

Are you pregnant? ◯ Yes ◯ No

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment? ◯ Yes ◯ No If so explain:

Circle/mark any of the following health conditions that you currently have (if you are unsure, please ask): Please answer honestly, as massage may not be indicated for the below conditions.

☐ Blood Clots ☐ Infections ☐ Congestive Heart Failure ☐ Contagious Diseases ☐ Pitted Edema

Please indicate the following conditions that you have or have had in the past. Explain in detail, including treatment received.

☐ Current ☐ Past Muscle or joint pain: _____

☐ Current ☐ Past Muscle or joint stiffness: _____

☐ Current ☐ Past Numbness or tingling: _____

☐ Current ☐ Past Swelling: _____

☐ Current ☐ Past Bruise easily: _____

☐ Current ☐ Past Sensitive to touch/pressure: _____

☐ Current ☐ Past High/Low blood pressure: _____

☐ Current ☐ Past Stroke, heart attack: _____

☐ Current ☐ Past Varicose veins: _____

☐ Current ☐ Past Shortness of breath, asthma: _____

☐ Current ☐ Past Cancer: _____

☐ Current ☐ Past Neurological (e.g., MS, Parkinson's, chronic pain): _____

☐ Current ☐ Past Epilepsy, seizures: _____

☐ Current ☐ Past Headaches, migraines: _____

☐ Current ☐ Past Dizziness, ringing in the ears: _____

☐ Current ☐ Past Digestive conditions (e.g., Crohn's, IBS): _____

☐ Current ☐ Past Gas, bloating, constipation: _____

☐ Current ☐ Past Kidney disease, infection: _____

☐ Current ☐ Past Arthritis (rheumatoid, osteoarthritis): _____

☐ Current ☐ Past Osteoporosis, degenerative spine/disc: _____

☐ Current ☐ Past Scoliosis: _____

☐ Current ☐ Past Broken bones: _____

☐ Current ☐ Past Allergies: _____

☐ Current ☐ Past Diabetes: _____

☐ Current ☐ Past Endocrine/thyroid conditions: _____

☐ Current ☐ Past Depression, anxiety: _____

☐ Current ☐ Past Memory loss, confusion, easily overwhelmed: _____

Comments

Consent for Treatment

If I experience any pain or discomfort during this 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/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/bodywork 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/bodywork 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. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____

Entering your name electronically constitutes a signature.