

# ~~Cindy Owens, LMBT~~Pregnancy Massage~~

## Health History Form/Pain and Discomfort Chart/Policies & Consent

In order to maximize the effectiveness and safety of your massage sessions, please take the time to carefully fill out this questionnaire. This information will be treated confidentially. Please print clearly.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

City, \_\_\_\_\_ State, \_\_\_\_\_ Zip Code: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_

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

How you prefer to be contacted: \_\_\_\_\_

Occupation(s): \_\_\_\_\_

If referred, referred by: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pre-natal Care Provider Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Have you had any previous experience with massage? Yes[ ] No[ ]

If yes, please explain whether for stress relief/relaxation, OR treatment of a specific condition diagnosed by a physician, OR pregnancy – OR any combination of the above:

Expected due date: \_\_\_\_\_

History of miscarriage? Yes[ ] No[ ]

Number of births: \_\_\_\_\_

Are you currently working? Yes[ ] No[ ] If yes, date of planned maternity leave: \_\_\_\_\_

Do you have high blood pressure? Yes[ ] No[ ] I'm not sure [ ]

Please mark [X] for all conditions that apply now. Put a [P] for past conditions.

[ ] headaches, migraines

[ ] nausea/morning sickness

[ ] fatigue

[ ] vision problems, contact lenses

[ ] heartburn/acid reflux

[ ] tension, stress

[ ] injuries to face or head

[ ] chronic pain

[ ] depression

[ ] sinus problems

[ ] muscle or joint pain

[ ] sleep difficulties

[ ] dental bridges, braces

[ ] muscle, bone injuries

[ ] allergies, sensitivity

[ ] jaw pain, TMJ problems

[ ] numbness or tingling

[ ] skin rash, sores, athletes foot,

[ ] asthma or lung conditions

[ ] sprains, strains, dislocations

nail fungus

[ ] constipation, diarrhea

[ ] arthritis, tendonitis

[ ] infectious disease

[ ] hernia

[ ] cancer, tumors

[ ] blood clots

[ ] abdominal or digestive problems

[ ] spinal column disorders

[ ] varicose veins

[ ] diabetes

[ ] hemorrhoids

[ ] heart, circulatory problems

[ ] other conditions not listed

Note if you see a doctor regularly (besides for pre-natal care) and for which of the conditions above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

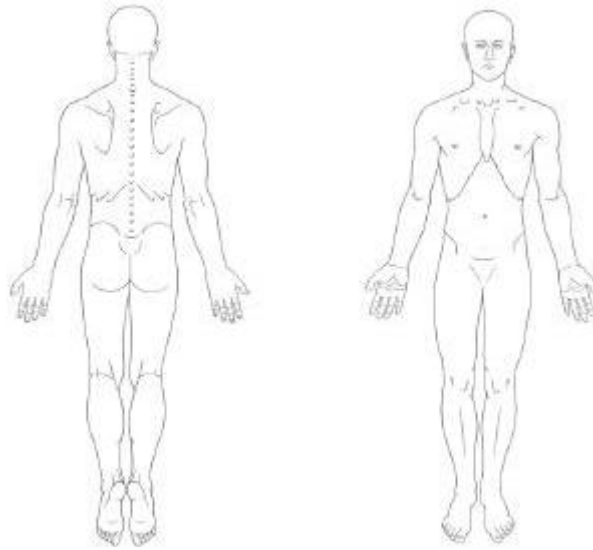
PLEASE CONTINUE ON THE BACK

Current medications you are taking including any nonprescription medications:

Have you had any surgeries within the last five years? If yes, please explain:

### *PAIN & DISCOMFORT CHART*

Please indicate the areas where you have pain and describe the level of discomfort using a scale of 1-10 - (A score of 1 being almost no pain and 10 being the highest level of discomfort).



For how long you have experienced pain/discomfort in the areas indicated on the pain chart?

Describe what makes the pain worse as well as methods you have tried that make the pain better:

What is your primary goal for today's session? (relaxation, pain relief, etc.):

### *General Information:*

I provide client-centered Pregnancy Massage, Swedish Massage and Myofascial/Deep Tissue Massage for relaxation and/or targeted to areas of pain.

**Rates:** 60 min. massage: \$65;  
90 min. massage: \$95.  
30 min. massage: \$40

**\*\* I prefer payment in cash or by check\*\***  
Appointments are scheduled by calling Salon Blue, 919-545-0107,  
or by calling Cindy directly at 919-548-3600

The massage will be tailored to your needs and a session plan will be discussed with you and will include your input. I will check with you concerning your comfort level with pressure, room temperature, etc. Please tell me at any time during and after the session about your comfort or how I could better address your needs for the massage. **This massage is all about YOU and you are in complete control of the session.**

~~~My intention is for you to have a relaxing and therapeutic massage experience.~~~

## *Policies:*

### **Your Rights:**

- ❖ All information, therapeutic discussions, casual conversations, records, either written or verbal during your visits, will be kept confidential. Information will be released only with your written consent or released by a court order, as required by law.
- ❖ Your comfort and level of modesty are of the utmost importance. I will ask you to remove your clothing only to your degree of comfort and will leave the room while you do so. You will always be draped during your massage with only the portion of your body being massaged uncovered. Prior to each session I will ask you if there are any parts of your body that you do not want touched.
- ❖ You have the right to discontinue treatment at any time, even during a session. Should this occur, it will be important for me to discuss and understand the nature of your discomfort and how/if it can be remedied.

### **My Rights:**

- ❖ By law, I have the right to refuse treatment, or to terminate a treatment in progress to protect my safety and well-being, including situations such as:
  - (1) a client who is abusive; under the influence of alcohol, drugs, or any illegal substance; or otherwise impaired; or
  - (2) A client who has violated the boundaries of the professional relationship by initiating or asking to engage in sexual activity.
- ❖ I also have the right to refuse or discontinue treatment of a client who does not disclose all health issues and information.

### **Cancellations & Late Arrivals:**

- ❖ Cancellations with less than 24 hours notice will be billed for the full amount of a session.
- ❖ You will pay for the full session even if you are late arriving for your appointment, but I will try to accommodate you depending on my scheduled appointments.

### **Lastly:**

- ❖ If you have a cold or other contagious illness or skin condition, these are contraindications for massage. Please wait until you are well.
- ❖ Please turn off your cell phone during the massage - this is your time to relax.

## *Consent:*

I, \_\_\_\_\_, understand that massage is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

By signing below I acknowledge that I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I also acknowledge that I have read and will do my best to abide by the policies listed above.

**Client Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

*You are finished! THANK YOU!*