~~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. <u>This information will be treated confidentially.</u> 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:_____

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
[ ] vision problems, contact lenses
[ ] injuries to face or head
[ ] sinus problems
[ ] dental bridges, braces
[ ] jaw pain, TMJ problems
[ ] asthma or lung conditions
[ ] constipation, diarrhea
[ ] hernia
[ ] abdominal or digestive problems
[ ] nausea/morning sickness
[ ] heartburn/acid reflux
[ ] chronic pain
[ ] muscle or joint pain
[ ] muscle, bone injuries
[ ] numbness or tingling
[ ] sprains, strains, dislocations
[ ] arthritis, tendonitis
[ ] cancer, tumors
[ ] spinal column disorders
[ ] diabetes
[ ] heart, circulatory problems
[ ] fatigue
[ ] tension, stress
[ ] depression
[ ] sleep difficulties
[ ] allergies, sensitivity
[ ] skin rash, sores, athletes foot, nail fungus
[ ] infectious disease
[ ] blood clots
[ ] varicose veins
[} hemorrhoids
[ ] other conditions not listed

Current medications you are taking including any nonprescription medications:

_____

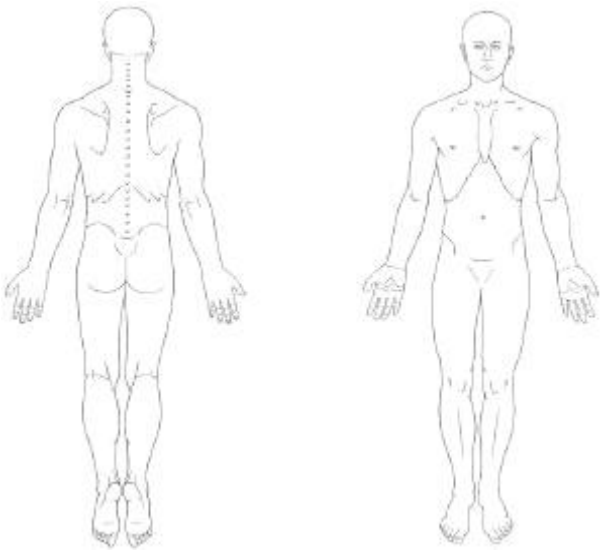
Have you had any surgeries within the last five years? If yes, please explain:

_____

PLEASE CONTINUE ON THE BACK

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:

_____

_____

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, including situations such as:
  (1) A client who is abusive, under the influence of alcohol or drugs, or is otherwise impaired; or
  (2) A client who has violated the boundaries of the professional relationship by behaving in a sexual way or asking to engage in sexual activity.
- You are required to be draped during the session. Requests for no draping will not be granted unless you are clothed.
- I have the right to refuse or discontinue treatment of a client who does not disclose his/her health information.

PLEASE CONTINUE ON THE NEXT PAGE

Cancellations & Late Arrivals:

- Please provide 24 hours notice of a cancellation or you may be billed for the 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 and put me at risk of infection. Please give me as much notice as possible of your need to reschedule.
- 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, contraindications, if any, and treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications.
- 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!