The Pause of Massage, LLC

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Welcome! I would like to make your appointment as pleasant and comfortable as possible.
If at any time you have questions regarding your session, please let me know.

Name ________________________________ *Phone* _______________________ *Do you text?* *Yes* *No*

Street Address ____

City _________________________ *State* _____ *Zip Code* _______________

Email Address ____ *Date of Birth* ____________

Preferred Communication (1st, 2nd, 3rd) Phone Call ____ *Text* ____ *Email* _____

Occupation ________________

Emergency Contact Name ____________________ *Phone Number* ______________ *Relationship* __________

How did you hear about The Pause of Massage? ____

Have you had a professional massage before? ______________

What are your goals for getting a massage?

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What is your preferred pressure? *Light* *Medium* *Deep*

Where do you carry your stress? ____

Do you have any allergies or sensitivities? *Yes* *No* *If yes, please explain:* ______________________

____

Please circle any of the following areas you do not want massaged:

Feet *Face* *Scalp* *Abdomen* *Buttocks* *Other:* ______________

Are you wearing contact lenses? ____ *Dentures?* _____ *Hearing Aid?* ____ *Prosthetics?* ____

Are you currently pregnant? *Yes* *No* *If yes, how far along?* __________

Any high risk factors to your pregnancy? ____

Do you suffer from chronic pain? Yes No If yes, please describe the pain (burning, dull, achy, deep, etc.). How long have you had the pain? ______________________________________

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Is there anything that makes the pain worse? ______________________________________

Is there anything that makes the pain better? ______________________________________

Are you taking any medication? Yes No If yes, please list here and what it treats:

____

____

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Have you had any surgeries? Yes No If yes, please list what and what year it happened:

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Please circle any of the following conditions that apply to you:

Cancer	*Fibromyalgia*
Headaches/Migraines	*Stroke*
Arthritis	*Heart Attack*
Diabetes	*Kidney Dysfunction*
Joint Replacement	*Blood Clots*
High/Low Blood Pressure	*Numbness*
Neuropathy	*Sprains or strains*
TMJ Dysfunction	*Varicose Veins*
Carpal Tunnel Syndrome	*Hight/Low Thyroid*
Whiplash	

Please explain any conditions you have marked: ______________________________________

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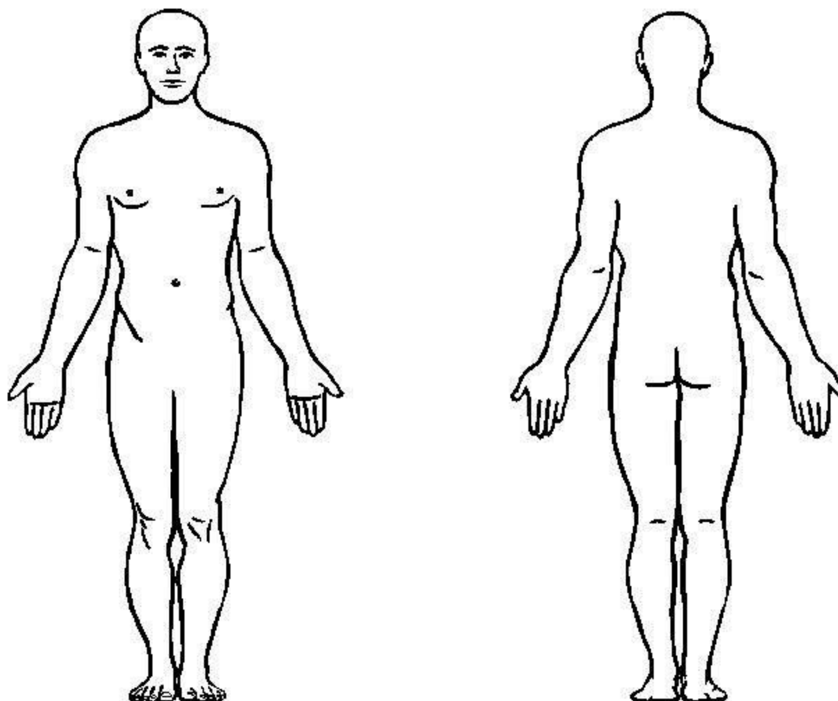
Please mark any areas of pain on your body on these diagrams.



Is there anything else about your health history you think would be useful for your massage therapist to know to plan a safe and effective massage session for you?   Yes   No   If yes, please list here:

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Informed Consent

I understand that a massage therapist does not diagnose disease or illness and cannot prescribe any treatment or medication nor do they provide spinal manipulations. I understand that draping will be used at all times . I understand if I become uncomfortable for any reason that I may ask the therapist to stop and they will end the session. I understand that the massage therapist may end the session for any inappropriate behavior. I understand if I cancel more than two massages with less than 24 hours notice within a calendar year, I will be charged the full price of the massage for the third cancelled massage (excluding cancelations due to poor weather).

By signing below, I agree that I have completed this form to the best of my ability and knowledge and agree to inform my massage therapist if any of the above information changes at any time.

Client Signature ______________________________   *Date* __________

Massage Therapist Signature ______________________   *Date* __________