



Pause & Unwind

Mobile Massage Service

Client Record

In order to maximize the effectiveness and safety of this massage sessions, please take the time to carefully fill out this questionnaire. This information will be treated confidentially. Your feedback is also appreciated at the end of the sessions to help in tailoring the massage session to serve in the best possible way. Please print clearly.

Personal information

Name: _____ Sex: M/F Date: ____/____/____

Home Address _____

Date of Birth: ____/____/____ Email: _____

Contact no: (C) _____ (H) _____ (W) _____

Emergency name and no: _____

Occupation(s):

Referred by: _____ Physician: _____ Ph.: _____

1. Have you had a professional massage before? YES NO

If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back or side? YES NO

If yes, please explain _____

3. Are you allergic to any oils? YES NO

If yes, please specify _____

4. Do you have sensitive skin? YES NO

5. Do you wear, contact lenses () Hearing aid () Dentures ()? NA ()

6. Do you sit for long hours at a workstation, computer or driving? YES NO

If yes, please describe _____

7. Do you perform any repetitive movements in your work, sport or hobby? YES NO

If yes, please describe _____

8. Do you experience stress in your work, family or other aspects of your life? YES NO

If yes, how do you think it has affected your health?

Muscle tension () Insomnia () Anxiety () Irritability () Other () _____

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort? YES NO

If yes, please identify _____

10. Do you have any particular goals in mind for this massage treatment? YES NO

If yes, please explain _____

Medical History

In order to plan a safe and effective massage session, I need some information about your medical history.

If you have a specific medical condition or specific symptoms, massage work may be contraindicated. A referral from your primary care provider may be required prior to services being provided.

11. Are you currently under medical supervision? YES NO

If yes, please explain _____

12. Are you currently taking any prescription medication? YES NO

If yes, please list _____

13. Please check any conditions listed below that applies to you:

- | | |
|--|---|
| <input type="radio"/> Phlebitis | <input type="radio"/> Contagious skin conditions |
| <input type="radio"/> Open sores or wounds | <input type="radio"/> Deep vein thrombosis/blood clots |
| <input type="radio"/> Easy bruising | <input type="radio"/> Joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="radio"/> Recent accident or injury | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Recent fracture | <input type="radio"/> Epilepsy |
| <input type="radio"/> Recent surgery | <input type="radio"/> Headaches/migraines |
| <input type="radio"/> Artificial joint | <input type="radio"/> Cancer |
| <input type="radio"/> Sprains /Strains | <input type="radio"/> Diabetes |
| <input type="radio"/> Current fever | <input type="radio"/> Fibromyalgia |
| <input type="radio"/> Swollen Glands | <input type="radio"/> Back and neck problems |
| <input type="radio"/> Heart condition | <input type="radio"/> Carpal tunnel syndrome |
| <input type="radio"/> High or low blood pressure | <input type="radio"/> Tennis elbow |
| <input type="radio"/> Circulatory disorder | <input type="radio"/> Hernia |
| <input type="radio"/> Varicose veins | <input type="radio"/> Pregnancy. If yes how many months? _____ |
| <input type="radio"/> Arteriosclerosis | <input type="radio"/> Digestive disorder/problem |

Please explain any conditions you have marked _____

14. How do you rate your health? Poor Good Excellent

If poor what do you need to change? _____

15. Is there anything else about your health and medical history that you think could be important for me to

know about? _____

Draping will be used during the massage – Only the area being worked on will be discreetly uncovered. A parent or legal guardian must accompany clients under the age of 17 during the entire session.

Please take a moment to carefully read the following information and sign where indicated

I _____ (client), understand that payment is due at the time of treatment unless other arrangements have been made prior to the session. I agree to give at least 24-hours advanced notice should I need to cancel an appointment; I understand that I will be responsible for payment of missed sessions. Cases of extreme emergency are considered exceptions to the cancellation policy.

I understand that the massage work I receive is provided for the basic purpose of relaxation and relief of muscular tension. 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 therapy should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or the qualified medical specialist of any mental or physical ailment that I am aware of.

I understand that massage therapists 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 sessions(s) given should be construed as such.

Because massage therapy is contraindicated 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 forget to do so.

It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session.

Client Signature _____

Date _____

Therapist Signature _____

Date _____