

THE TEAL CENTER
For Therapeutic Bodywork, Ltd.



Health/Lifestyle History

Name _____

Mailing Address (please include zip code) _____

Daytime phone _____

Mobile Phone _____

Email address _____

Date of birth ___/___/_____

Emergency Phone Contact (Name and Phone) _____

What is your occupation? _____

Had you ever received bodywork before your cancer diagnosis? ____ If so, what types? _____

Have you received bodywork since your cancer diagnosis? ____ If so, when and what types? _____

Do you see a chiropractor? If so, how often? _____

Why have you come for massage today?

Is there anything specific that you hope to achieve through massage?

When were you diagnosed with cancer? ____ What type of cancer? _____

Where is/was it located? _____

Are you being treated now? Yes No If no, what was the last date of your treatment?

What **treatments** have you undergone or are you currently undergoing? *Please supply dates and types of treatments to the best of your ability.*

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Please list any **medications** you are currently taking, in addition to any chemotherapy drugs listed above, and any **side effects** you experience.

Medication

Side Effect

Did your treatments include any **removal or irradiation of lymph nodes?** (if yes, please describe)

To your knowledge, do you have any **site restrictions** due to :

- incisions, open wounds, dressings
- skin condition, rash or sensitivity
- medical devices such as IV or ostomy
- tumor site radiation site(s)
- a history of blood clots or phlebitis
- bone or spinal metastases neuropathy
- history of fractures bone fragility
- area of infection other (please describe) _____

To your knowledge, do you have any **pressure restrictions** due to:

- history of risk of lymphedema
- anticoagulants low platelet count bone metastases
- steroid medication fragile/sensitive skin fragile veins
- area(s) of pain or burning fatigue recent surgery
- infection or fever other (please describe) _____

Do you have any **position restrictions** due to:

- incision medication ostomy tumor site difficulty breathing tender skin
- swelling or risk of swelling (any area of the body require elevating?) please describe

medical devices _____

discomfort _____

Has cancer or cancer treatment affected any of the following functions in your body?

- lungs liver nervous system heart kidney blood counts energy level

If yes, please describe _____

General Signs and Symptoms

<i>Check "yes" & add further comments if you have had any of the following sign/symptoms</i>	Yes	No	Comments
Swelling or tendency to swell anywhere in your body			
Sites of pain/tenderness			
Sites of numbness/diminished sensation			
Inflammation			

Specific Medical Conditions

<i>Check "yes" & add further comments if you have had any of the following sign/symptoms</i>	Yes	No	Comments
Skin conditions (rashes, infections, allergies, itching)			
Known allergies/sensitivities (Do you use any non-allergenic or physician-approved lotion?)			
Cardiovascular conditions (e.g. heart condition, angina, high blood pressure, atherosclerosis, phlebitis, thrombosis, etc)			
Liver or kidney conditions			
Respiratory or lung conditions			
Diabetes			
Arthritis			
Injuries (e.g. disc problems, tendonitis, knee problems, fractures, etc)			
Surgery			
Any conditions NOT MENTIONED			

How would you rate your **diet**? Very Healthy ____ Somewhat Healthy ____

Not Very Healthy ____ Needs Improvement ____

How much uninterrupted **sleep** do you get each day, on average? ____ none ____ 1-3 hours ____ 4-5 hours ____ 6-7 hours ____ 8+ hours

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If you are having trouble sleeping, what is the primary reason? ___ anxiety ___ pain
___ outside interruption (family, noise, etc) ___ other (please explain) _____

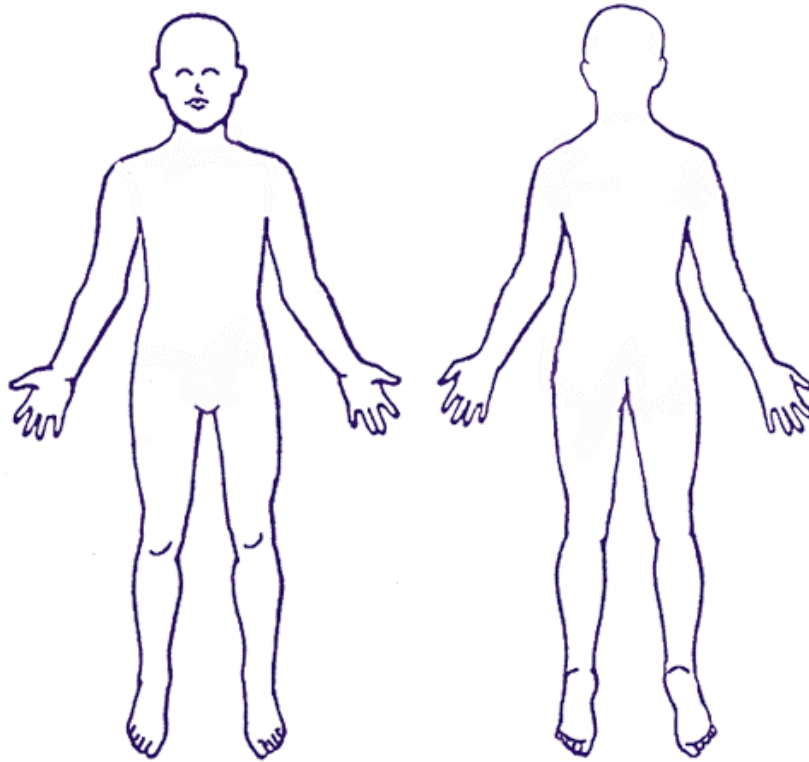
On average, how much **water** do you drink each day? (as a reference, a soft drink can contains 12 oz.) Less than one 8oz. Glass _____

More than five 8oz. Glasses _____ Eight or more 8oz. glasses _____

Are you **able to relax**? Yes No If so, What do you usually do to relax?

Is there **anything else** that you think I should know? _____

Please indicate any areas of discomfort or pain on the diagrams below. Rate your discomfort in each area using a scale of 1-10. 1= very mild ; 10= extreme, intrusive pain



Feel free to make notes next to any areas of pain that you feel require explanation.

Thank you!

The Teal Center for Therapeutic Bodywork, Ltd.

CLIENT AGREEMENT

HIPPA regulations require the following signed authorization:

I (name)_____ (address)_____ give permission for my Teal Center practitioner to take notes about me, including health history/medical and/or personal information I choose to disclose. I understand that this information will be kept strictly confidential.

I also understand:

1. That massage therapy and/or acupuncture
 - ◆ is for the purpose of stress reduction, relief from muscular tension and spasm, general relaxation and improvement of circulation and energy flow;
 - ◆ is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.
2. That the massage therapists and/or acupuncturists
 - ◆ do not diagnose illness, disease or any other physical or mental disorder;
 - ◆ do not prescribe medical treatment or pharmaceuticals; and
 - ◆ do not perform any spinal manipulations.
3. That any and all of my appointment times are reserved exclusively for me and that I am responsible to remember them and to pay for appointments that I miss or cancel with less than 24 hours notice.

I authorize The Teal Center to charge my credit card on file for the full amount of any appointment missed or cancelled with less than 24 hours notice.

I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Name_____

Signature_____ Date_____

Welcome! And thank you for choosing The Teal Center.

Please read and ***initial*** each of the following

POLICIES

_____ Appointments missed, cancelled or rescheduled with less than 24 hours notice will be charged in full. To avoid being charged for a missed appointment, we invite you to send a friend or family member in your place. Also, if we can fill appointments that are missed, cancelled or rescheduled with less than 24 hours notice the client will not be charged. *It is your responsibility to remember your appointments.* Confirmation calls are made 36-48 hours prior to the scheduled appointment.

_____ The Teal Center and its practitioners abide by the ethical standards of practice established by their respective certification boards (NCBTMB and NCCAOM). All clients shall refrain from any behavior that sexualizes or appears to sexualize the client/therapist relationship. If such behavior occurs at any time, therapists are instructed to terminate the session; payment will be made in full by the client and the Teal Center reserves the right to prohibit the client from returning to the Teal Center.

_____ If you have a cold or other contagious illness, please call us before your appointment so we can check with your therapist to see if it is appropriate for you to come in.

_____ In order to preserve a peaceful environment, we ask that you silence your cell phones while at The Teal Center.

_____ Tips are appreciated but *never* expected. If you wish to leave a gratuity for your therapist we ask that you do so in cash or by check made directly to the therapist.

_____ If you move or change phone numbers, it is your responsibility to inform us. This is important so we can reach you in case of any emergency or any necessary and unforeseen scheduling changes.

_____ The Teal Center does not submit insurance claims. We are happy to provide you with medical receipts, any treatment notes and payment history for your personal records. We will communicate directly with your insurer *at their request only.*