

The Teal Center for Therapeutic Bodywork, Ltd.

CLIENT INFORMATION

Please print

Name _____ Today's Date _____
Last First Middle

Address _____

City _____ State _____ Zip _____ E-mail _____

Telephone (H) _____ (W) _____ (Cell) _____

Occupation _____ Birth Date _____ Referred by _____

Emergency Contact: _____
Name Phone number

Would you like to receive e-mail notifications on promotional discounts/ newsletter? YES NO

Have you had professional bodywork before? _____ If so, what kinds? _____

What are you looking for in your bodywork today? Relaxation _____ Pain Relief _____
Injury Rehabilitation _____ Other _____

What are your primary areas of pain, discomfort or tension? _____

How long have you had this discomfort? _____

What do you think is the cause of this discomfort? _____

Have you had previous treatment for this discomfort? Yes _____ No _____ If yes, please describe: _____

Are you presently under a doctor's or therapist's care? Yes _____ No _____

If so, for what? _____ If we have questions, may we contact them? _____

Physician's or therapist's name _____

Please list any medications you are taking and what they are for _____

Rate your normal stress level: 1(low) to 10 (high) _____ Rate your current pain level: 1-10 _____

Rate your general health: Excellent _____ Good _____ Fair _____ Poor _____

Do you have any allergies? _____ If so, to what? _____

Do you smoke? _____ Do you wear contact lenses? _____ Do you take supplements? _____ If so, which ones? _____

What do you do for exercise, and how often? _____

(Females only) Are you pregnant? _____ If so, when is your due date? _____
Have you had any complications? _____ Obstetrician's name: _____

Please circle any of the following conditions which you currently have or have experienced within the last 6 months. Some may be contraindications for massage.

Systemic Infections: ___ Mononucleosis ___ Flu ___ Hepatitis ___ Fever ___ Other _____

Cardiovascular: ___ Varicose veins ___ Stroke ___ Acute inflammation
___ Phlebitis ___ High blood pressure ___ Heart attack
___ Blood clots ___ Low blood pressure ___ Heart disease

Skin infections: ___ Eczema ___ Burns ___ Other _____

Musculo-Skeletal: ___ Neck pain or stiffness ___ Low back pain ___ Sports injuries: _____
___ Shoulder pain ___ Hip pain/sciatica ___ Fractures: _____
___ Upper back pain ___ Knee pain ___ Sprains/strains: _____
___ Arm pain ___ Leg pain ___ Torn ligaments/cartilage/tendons
___ Hand pain ___ Foot pain ___ Whiplash
___ Carpal tunnel ___ Scoliosis ___ Arthritis ___ Fibromyalgia
___ Other RSI: _____ ___ Osteoporosis ___ TMJ dysfunction/jaw pain
___ Tension headaches ___ Migraines ___ Tinitis/ringing in ears

Neurological: ___ Disc disease ___ Numb, weak or cold extremities ___ Twitches/jumpiness
___ Seizures ___ Chronic Fatigue Syndrome ___ Other _____

Endocrine: ___ Diabetes ___ Hypoglycemia ___ Other _____

Respiratory: ___ Emphysema ___ Hay fever ___ Asthma ___ Other _____

Reproductive: (Females) ___ Menstrual cramps ___ PMS ___ Other _____
(Males) Prostatitis Other _____

Digestive: ___ Constipation ___ Diarrhea ___ Colitis ___ Crohn's disease ___ Other _____

Psychiatric: ___ Mood swings ___ Sleep disorders/insomnia ___ Exhaustion ___ Depression
___ Acute anxiety ___ Panic disorder ___ Other _____

Please describe any past surgeries, automobile accidents, serious falls, or other injuries and include dates if possible.

Please describe any diagnosis of cancer, including date of diagnosis and type of treatment. _____

Is there anything else I should know about you, your health, or your body before administering massage therapy? Please describe: _____

Signature _____ **Date** _____

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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.*