Personal Information

Name _____ Phone _____

Address _____ City/State/Zip _____ DOB _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

Who referred you to us? _____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Do you have any hardware in your body? ☐ yes ☐ no

If yes, please list: _____

Please indicate any of the following that apply to you.

☐ Cancer
☐ Headaches/Migraines
☐ Arthritis
☐ Diabetes
☐ Joint Replacement(s)
☐ High/Low Blood Pressure
☐ Neuropathy
☐ Fibromyalgia
☐ Stroke
☐ Heart Attack
☐ Kidney Dysfunction
☐ Blood Clots
☐ Numbness
☐ Sprains or Strains

Explain any conditions you have marked above:

_____

_____

_____

_____

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____

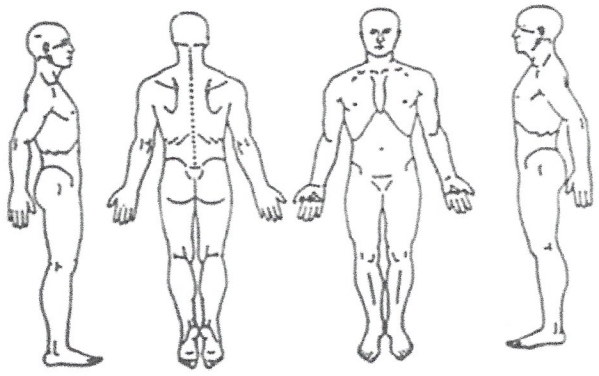
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain _____

What are your treatment goals long term?

_____

Please circle any areas of discomfort



By signing below you agree to the following.

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

Client Signature _____ *Date* _____

Care Plan Satisfaction Questionnaire

Teall Massage is a cash only practice and charges according to the time a client is seen, not by services rendered. Your first visit will include a consultation to ensure your best treatment possible, and your session will be shorter depending on your consultation needs.

The following questions are to assist your provider in you leaving every visit feeling 100% happy about your care. If you prefer to do this questionnaire verbally, then feel free to let your provider know.

Describe your experience with massage therapy?

(Brand new, relaxation only, treatment work for accident, pain management, athletic goals, etc)

What do you want out of your care here?

(Massage when I feel like it, new therapy options, decrease pain, increase mobility, better sleep, anxiety, energy)

Emotional release/trauma recognition can be common with long term injury, if there is anything you would like your provider to know, you can include it here safely.

Do you have any family that also needs to be seen? What is the reason?

(Anyone listed here will receive 20% off of their initial visit with Teall Massage.)

Is there anything that annoys or bugs you during a massage?

(Too much paperwork 😊, Touching feet, talking, silence, loud music, piano, too warm, more pressure, too much pressure.)

Are you comfortable telling your provider when the pressure is too much or too little, or would you like your provider to check in occasionally?

Are there any scents or products that you do not prefer?

Are you interested in Cupping Therapy? Y N

Are you interested in Aromatherapy Y N

Are you interested in CBD? Y N

Are you interested in Cranial Sacral? Y N

Are you interested in ADHD/Anxiety Care? Y N

Are you interested in Thai Table Massage? Y N

Pectoral work and Gluteal work is commonly used in Massage Therapy for releasing specific muscle groups and improving ROM, decreasing pain and other benefits. Your comfort and safety always come first. Each visit, you will sign a consent and be able to choose at any time what you are comfortable with. You will be draped properly and modestly throughout your session. If you have any further privacy/draping preferences, please let your provider know. You are welcome to ask for a recommendation to another provider at any time. Massage therapy requires clear and safe communication, and everyone has their own preferences. If you prefer another type of care, we are always happy to assist you in finding what suits your needs at the time.

Looking forward to Healing with you!

Teall Massage

Precautionary Coronavirus Liability Release Form

Due to the 2019-2020 outbreak of the novel Coronavirus, COVID-19, we are taking extra precautions with the intake of each client, health history review, as well as sanitation and disinfecting practices. Please complete the following and sign below.

Symptoms of COVID-19 include:

- Fever
- Fatigue
- Dry cough
- Difficulty breathing

I, _____ agree to the following:

I understand the above symptoms and affirm that I, as well as all household members, do not currently have, nor have experienced the symptoms listed above within the last 14 days.

I affirm that I, as well as all household members, have not been diagnosed with COVID-19 within the last 30 days.

I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the last 30 days.

I affirm that I, as well as all household members, have not traveled outside of the country, or to any city outside of our own that is or has been considered a "hot spot" for COVID-19 infections within the last 30 days.

I understand that this business and my massage therapist cannot be held liable for any exposure to the virus or any other contagion caused by misinformation on this form or the health history provided by each client.

By signing below I agree to each above statement and release the massage therapist and business from any and all liability for the unintentional exposure or harm due to COVID-19.

Your massage therapist and all employees of this facility agree that they abide by these same standards and affirm the same. We also affirm that we have improved and expanded our sanitation protocols to more thoroughly fight the spread of COVID-19 and other communicable conditions.

Signature _____ Date _____

TEALL MASSAGE

DT SCR HS C RX PRN

General Liability Release Form

By signing below, you agree to the folowing:

1. I give my permission to receive massage therapy.
2. I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.
3. I understand that it is my responsibility to inform the therapist of any conditions which may worsen or become inflamed or dangerous as a result of a massage.
4. I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications. Anything talked about within session is not a recommendation or prescription.
5. I have clearance from my primary care physician to receive massage therapy.
6. I understand that I cannot receive any form of breast massage, regardless of gender. Draping will be continued on pectoralis/breast work, as well as abdominal work.
7. I understand the risks associated with massage therapy include but are not limited to superficial bruising, short-term muscle soreness, exacerbation of any undiscovered injuries. I therefore release the business location and the indicidual massage therapist from all liability concerning these injuries that may occue during or after the massage session.
8. I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so that the therapist may adjust accordingly. I understand that I or the massage therapist may terminate the session at any time.
9. I understand that cupping and scraping can leave bruising or marks on my body and accept this risk.
10. I understand that no minor is allowed to receive massage therapy without a guardian adult present in the session.
11. I understand that it is my responsibility to inform the therapist of any allergies or sensitivities, including to smell or linens.

Signature:_____ Date: _____

Guardian Signature: _____

Printed Name of Minor: _____

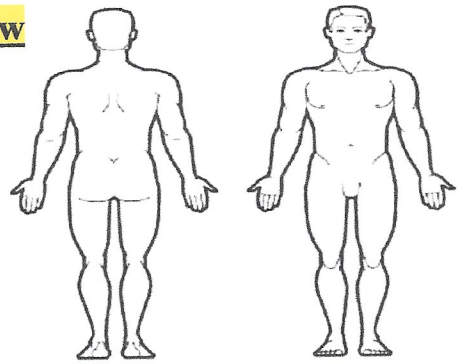
TEALL MASSAGE

Client Name:_____

Date:_____

Daily Tracking- Fill in Only the Yellow

S: PAIN LEVEL: 1 2 3 4 5 6 7 8 9 10



Circle for yes/ X for No Massage

Check all that apply:

_____Dull Ache_____Sharp Pain_____Constant Pain_____Occasional Pain

_____Numbness_____Loss of sleep_____Mood Changes_____Headaches

What are we treating today?:_____

How did you feel after your last visit?_____

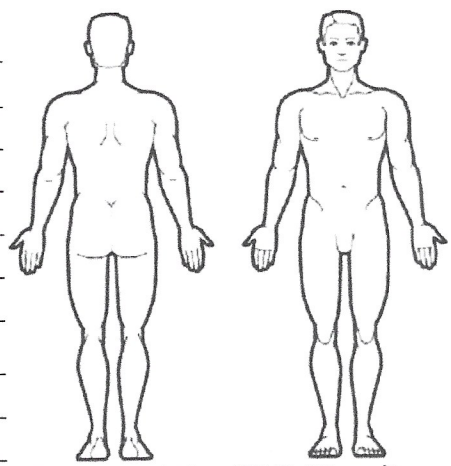
Which Activities/Movements are Limited?_____

____I give my consent to receive pectoral massage during this session____I give my consent to receive Gluteal massage during this session.

Client Signature:_____Date:_____

Informed Consent: The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. I agree to inform the therapist of any experience of pain during the session. I agree to update the therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part should I forget to do so. I agree to hold harmless the establishment, business, and all management, including volunteers from any and all claims. I agree to handle suit at its sole expense and agree to bear all costs related even if claims, etc, are groundless, false, and fraudulent. I understand that by signing above, I am giving my consent for the Massage Therapist to preform breast massage that includes pectoralis muscles, lower body massage including Glute Muscles, and abdominal massage. I understand that my modesty will be protected and I will remained draped properly and safely during my session.

O:_____



A:_____

TX: 60 90 DT SW CP MFR CRS Heat/Ice

P: Stretches/Increase Water/Ice Home/Heat Home/Follow up:_____

STG:_____

LTG:_____

Provider Signature: Rebecca Hradlicka, LMT Date:_____

Additional Notes:

TP @ ADH ≈ HT = Pain ✳ Infl ◯ Numb SS Shooting ↑↓ Elev / Short — Long ÷

TEALL MASSAGE

Client Name:_____

Date:_____

LMT Shorthand Notes

S = Subjective. This section includes information that the client tells you in his or her own words.
O = Objective. Includes your clinical findings and observable data (posture, muscle tone, ROM, temperature, swelling)
A = Assessment. Your assessment or analysis of client response to treatment and progress towards goals.
P = Plan. Includes your plan for their next visit, and any instructions that you gave the client.

TP	ADH	HT	Pain	Infl	Numb	Shooting	Elev	Short	Long