Tara's Touch & Wellness

Tara Lewallen CMP

Name _____ DOB _____
Address _____ City_____ State ____ Zip _____
E-mail: _____ Phone (_____) _____
Occupation _____ Referred by: _____
In case of emergency: _____ Phone (_____)_____

About You
_ Yes _ No Do you frequently suffer from stress?
If so, how do you manage it? _____
_ Yes _ No Do you often experience headaches or migraines?
_ Yes _ No Do you have tension or soreness in your body? Please specify_____
_ Yes _ No Are you sensitive to touch or pressure in any area?
_ Yes _ No Do you bruise easily?
_ Yes _ No Do you suffer from joint swelling? Please Specify_____
_ Yes _ No Would you say you frequently suffer from pain?
If so, where & how do you manage it? _____
_ Yes _ No Do you have numbness, tingling or stabbing pains?
_ Yes _ No Any serious injuries in the past two years? Please Specify_____

Medical History
_ Yes _ No Are you pregnant?
_ Yes _ No Do you suffer from arthritis? Please Specify _____
_ Yes _ No Do you have diabetes?
_ Yes _ No Do you have high blood pressure?
_ Yes _ No Do you suffer from epilepsy or seizures?
_ Yes _ No Do you have raised varicose veins?
_ Yes _ No Do you have cardiac or circulatory problems?
_ Yes _ No Do you have any contagious diseases? Please Specify _____
_ Yes _ No Do you have osteoporosis?
_ Yes _ No Do you have any allergies? Please Specify_____
_ Yes _ No Other medical conditions or medications I should know about?_____

Massage Preferences
Have you experienced a professional massage session before? _ Yes _ No How long ago? _____ Regularly? _ Yes _ No
What are your goals for todayôs session? _____
What kind of pressure do you prefer? _ light _ medium _ firm Any areas of the body you would like to avoid?_____
Which area of the body is your favorite to be massaged? _____ May I use hot stones during your massage? _ Yes _ No
May I stretch your body during the massage? _ Yes _ No May I use muscle soothing creams and oils on your body? _ Yes _ No

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the massage/bodywork 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 or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners 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 session given should be construed as such. Because massage/ bodywork should not be performed 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 practitionerôs part should I fail to do so.

Client Signature _____ Date _____
Consent to Treatment of Minor: By my signature below, I hereby authorize the use of massage and bodywork techniques to my child or dependent.
Signature of Parent or Guardian _____ Date _____

Would you like to be informed about Price Specials? ___ Yes ___ No Circle best contact source Text or Email
Gift Certificates are available for specified monetary amounts or for specific services.
Referral Program: If you refer a friend, you will receive $10 off your next appointment! Thank you in advance!! ☺