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 today's 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 practitioner's 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.

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FULL SPECTRUM INFRARED TREATMENT RELEASE FORM

Name:_____ Age:_____

1. I have read and understood the contraindications page on the Tara's Touch Website or on the BioMat website.
2. The use of drugs or alcohol prior to or during the infrared session may lead to dizziness or unconsciousness.
3. Please consult your physician if you are in doubt of your ability to use infrared therapy for any health reasons.
4. No clients under the age of 18 are permitted to do infrared treatment unless accompanied by a supervising adult.
5. Please discontinue the use of the infrared therapy if you feel light-headed, dizzy, sick or heat exhausted.
7. It is advised to drink plenty of water or electrolyte enhancing beverages before and after your infrared session.
8. Clients using any prescription medications must consult a physician prior to the use of the infrared therapy.
9. Pregnant women should not use the sauna… and should seek their physician's approval before using the BioMat.
10. Clients with a medical history of circulatory system problems should consult a physician prior to using infrared therapy.

I acknowledge and accept the risks inherent in the use of this Sunlighten sauna and/or the BioMat. I voluntarily assume the risks which may arise. I and any of my heirs, executors, representatives, or assigns hereby release Tara Lewallen/Tara's Touch from all claims or liabilities for personal injury or property damages of any kind sustained while on the premises, during the use of this Sunlighten sauna or BioMat… from any advice provided by an employee, independent contractor or any representative.

I further understand that Tara Lewallen/Tara's Touch is **NOT A Medical Doctor** and is **NOT** attempting to portray, or conduct the activities of a Medical Doctor and I release her, the Facility and Manufacturer from any adverse effects I may incur by the use of the Sunlighten sauna or the BioMat.

I have carefully read the above safety instructions for using the Sunlighten sauna and BioMat. I fully understand them and fully agree to comply with instructions. This agreement is in effect for all infrared therapy sessions/treatments and will not expire unless the client requests to void the contract in writing.

Client Signature:_____ Date:_____

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CONFIDENTIAL COVID-19 QUESTIONNAIRE

1. Have you been ill with a cough, fever or had any difficulty breathing in the past 2 months?

Yes or No

If yes, please explain:

2. Have you had any flu symptoms (stomach upset, headache or fatigue) in the past 2 months??

Yes or No

If yes, please explain:

3. Have you experienced any recent loss of taste or smell?

Yes or No

If yes, please explain:

4. Has anyone in your home had any of the symptoms listed above in the past 2 months?

Yes or No

If yes, please explain:

5. Do you have any preexisting conditions that I should be made aware of?

Yes or No

If yes, please explain:

6. Have you or anyone in your family been exposed to a person with COVID-19?

Yes or No

If yes, please explain:

7. Have you traveled outside of the country since February 2020?

Yes or No

If yes, please explain:

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COVID-19 PANDEMIC WAIVER

I, _____, have honestly answered all the questions on the back side of this sheet, and I fully understand the risks associated with receiving a massage during the Corona Virus Pandemic. I am entrusting Tara Lewallen/Tara's Touch & Wellness to provide massage & wellness services for me today. I will in no way deem her or her business liable in any way for any consequences that may occur as a result of taking this personal risk... including but not limited to the contraction of the Corona Virus. If I, anyone in my household or anyone I have been in contact with tests positive for Corona Virus within 2 weeks, I will contact Tara immediately.

Customer Signature _____ Date:_____ Temp:_____

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Customer Signature _____ Date:_____ Temp:_____

Customer Signature _____ Date:_____ Temp:_____

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