A Transformation Station LLC

healthfully experience change

PARTICIPANT RECORD

Name: ____

Address: ____

____

Phone(s): Home ______________________

Work ______________________

Cell ______________________

E-mail: ____

Birth Date: ______________ **Referred by:** ______________________

Emergency contact: Name ______________________________

Phone ______________________

Charges/ Attendance

Date														
Massage Therapy														
Consult														
Sampler session														
Full session														
Misc.														
Gift Certificate														
Missed Appt. Fee														
Workshop/Class														
Other:														
Total Charge														
Paid By														

Date														
Massage Therapy														
Consult														
Sampler session														
Full session														
Misc.														
Gift Certificate														
Missed Appt. Fee														
Workshop/Class														
Other:														
Total Charge														
Paid By														

Key: C=cash, CK=check, CC=credit card, GC=gift certificate, P=package

Notes: ____

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A Transformation Station LLC

- Therapeutic Massage and Bodywork -

CONSENT

Consent for Treatment: I have requested and hereby authorize the licensed massage therapists of A Transformation Station LLC to provide me with the appropriate therapeutic massage and bodywork services within each service provider's scope of knowledge and practice. I understand that massage therapy does NOT include medical diagnosis or any service/procedure for which a license to practice medicine is required by law.

Client: ____ **Date:** ______________
Witness: ______________________________________

AGREEMENTS

1) Release of Information: I hereby authorize the therapeutic professionals and staff of A Transformation Station LLC to discuss within their organization information regarding my health status and treatments. I am responsible for providing medical and other pertinent updates. I may request to view and have copies of the content in my medical record. I also authorize the necessary communication with the following health professionals or persons.

____ __________ ___________
____ __________ ___________
____ __________ ___________
____ __________ ___________

2) Payment: I agree to make payment for all services provided to me at the time of service.

Client: ____ **Date:** ______________
Witness: ______________________________________

ACKNOWLEDGEMENTS

1) Privacy Practices: I have been provided an opportunity to review a copy of A Transformation Station LLC's Privacy Policy.

Initials: ____________

2) Attendance Policy: I understand that 24 hours notice is required for cancellation of appointments. There is a $15.00 charge for missed appointments and short notice cancellations.

Initials: ____________

3) Email - Re/News Blasts +: I am giving permission to receive the occasional email newsletter and periodic therapeutic appointment and event reminders.

Initials: ____________

PRIVACY POLICIES

Use and Disclosure of Your Medical Information

- **About Treatment:** Your medical information will be used to provide you with the therapeutic services. This information is only disclosed to the healthcare professionals, legal representatives, payment providers or family members that you specify on the Release of Information form.
- **Attendance and Fees for Payment:** Although we rarely take insurance to pay for our services, you may request more formal receipts for flexible spending plans, insurance or tax purposes. These can include your doctor's name, diagnoses and treatment codes.
- **For Unusual Circumstances:** In the event of an emergency and you are unable to give or refuse permission to share information to medical personnel or law enforcement, I will only share the health information that is pertinent to your well-being in that situation. The person that you request to be contacted in an emergency may also be involved in any communication.

Participant Confidentiality

- Please understand that just as your medical information is confidential, so is information about the other participants. Therefore, we will not be able to discuss their medical condition or progress unless authorized to do so with you. If you have questions, you may talk to them directly.
- Occasionally, examples of other people's conditions or progress are mentioned to help you with your healing process. Specific names will not be used. Note that these may include examples from the past 40 years.

Marketing – Business

- We will not sell demographic information to other companies for marketing purposes.
- We also will not use your health information in marketing our services without your permission.
- From time to time, we may recommend information, classes, programs and/or another professional's services to assist you in attaining your holistic health-related goals.
- Note that any demographic info that is exchanged over the internet as in email correspondence and the website is not totally immune from retrieval. The scheduling system and payment system have their own built-in high privacy safeguards.
- **Disclaimer:** We ask that everyone use their own judgement concerning the knowledge, techniques and beliefs that are shared in the therapeutic and educational services. Remember that this space offers the opportunities for healthcaring and that each participant (both as a giver and receiver) is responsible for his/her own well-being. One has a choice on how, when and whether to safely integrate any changes in thought, feeling or action into their life as it is our goal for all involved to "healthfully experience change" toward wellness. Therefore, discussions and feedback are encouraged. In reality, we are still figuring out this thing called "healing" and are striving for our best. Let's help each other in the process.

A Transformation Station LLC

- Therapeutic Massage and Bodywork -

ADDITIONAL INFORMED CONSENT

Consent for Treatment during COVID-19 pandemic:

I understand that close contact with people increases the risk of infection from COVID-19.

By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive therapeutic massage and bodywork services from this practitioner.
I am aware that an action plan exists should someone associated with this therapeutic facility (practitioner, client, guest) test positive for a current COVID-19 infection.
This includes notification to others who may have been exposed (up to 2 weeks prior), testing, contact tracing and possible self-quarantine.

Client: ____ **Date:** _______________
Witness: ______________________________________

ACKNOWLEDGEMENTS

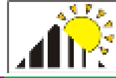
1) Health History Updates: I am aware that I should call ahead of my scheduled appointment if I suspect illness or exposure to COVID-19. Massage therapy might not be advised. A phone session may be an option. A cancellation fee will not be charged.

I understand that a series of questions will be asked about my potential exposure to COVID-19 before entering the premises at each appointment. These are posted on the website.

Initials: _____________

2) Adjusted Appointment Routines: I acknowledge that I have been given a list of modifications to the therapeutic session appointment routine. These include topics such as the wearing of face coverings, temperature screenings, informed consent, hand washing, using hand sanitizer, use of gloves, proper attire, options for "no touch" areas, social distancing as able, coughing/sneezing considerations, check-out procedures and cleaning/sanitizing methods. Changes to these will occur as recommended by the state and CDC.

Initials: _____________

Participant History Form 

Name: ____ Date: ____________________________

Age: ________ Height: _________ Weight: _________ Hand Dominance: □ Left □ Right

Social History:

Live: □ Alone □ with Spouse/Partner □ with Friend(s) □ with Children □ other ________________________

Occupation: ______________________________ Employer: ___________________________________

Are you presently working? □ Yes □ No, date last worked _______________

School/College completed: ____ Year: ______________

Sports/Recreational Activities/Hobbies: ____

Medical History:

Doctor(s): ____

Do you participate in: □ Flexible Medical Spending Plan □ Complementary Medicine Discount Plan?

1. What are the concerns, medical diagnoses, challenges that you wish to address? (list dates of onset /cause if known)
   ____
   ____
   ____
2. Have you had massage therapy or other treatment for these? □Yes □No If yes, please describe.
   ____
   ____
3. Check if you have had the following medical tests (indicate significant results):

   □ EMG ________________ □ MRI _______________ □ Blood work _____________

   □ X-ray ________________ □ EKG _______________ □ Other _________________
4. List any surgeries that you have had and the dates: ____
   ____
5. List any medications that you are taking: ____
   ____
6. Check those that presently apply:

□ Heart Abnormalities	□ Pregnant	□ Pain
□ High Blood Pressure	□ Respiratory Problems	□ Limited Motion
□ Diabetes	□ Vascular Problems	□ Numbness/Tingling
□ Cancer	□ Skin Conditions	□ Swelling
□ Seizures	□ Digestive Problems	□ Weakness/Fatigue
□ Metal Implants	□ Allergies	□ Sleep Disturbances
□ Pacemaker	□ Mental Illness	□ Other: ____________

1. Check those that you presently wear or use:

□ Foot Orthotics	□ Contact Lenses/Glasses	□ Walker/Cane
□ Orthodontic Braces	□ Joint Brace	□ Wheelchair
□ TMJ Appliance	□ Splint	□ Other: _____________
□ Dentures	□ C-PAP Machine	

2. Check those that you have access to or presently use:

□ Weights	□ Gym	□ Bike/Elliptical
□ Therapy Ball	□ Pool	□ Exercise Classes

3. What do you wish to accomplish from therapeutic massage and bodywork? (physical/emotional/mental goals)

____
____
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4. List significant impact-related experiences in your life (physical/emotional/mental):
Include your age or date, type of incident, outcomes or injuries.

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If you have pain, please complete the next page.

Pain History:

1. Shade any painful areas:

PAIN CHART

Left Right Right Left

RIGHT SIDE LEFT SIDE

2. How often do you have pain? (constantly, intermittently, time of day) ______________________________________

3. Describe your pain (aches, throbs, burns, shoots, cramps, etc.): ____

4. Rate the severity of your pain on this scale (please circle):

At Rest 0 1 2 3 4 5 6 7 8 9 10
None Moderate Excruciating

With Activity 0 1 2 3 4 5 6 7 8 9 10
None Moderate Excruciating

5. What makes your pain worse? (weather, prolonged activity, time of day, certain positions, etc): ________________
____

6. What relieves your pain? (medications, rest, heat, ice, exercises, etc.): _____________________________________
____

7. What activities does pain keep you from doing? (sleeping, driving, self-care, school, work, housework, hobbies/sports)

____