Informed Consent Agreement

By signing, **Client** acknowledges having read and agreeing to all terms of receiving bodywork. Any questions should be asked prior to receiving bodywork. **Client** also releases **Therapist** and **Bodywork Therapies, LLC** from responsibility for any conditions that may arise during or after receiving bodywork.

General Benefits: Increases in circulation, toxin removal, range of motion, flexibility, energy, heart rate, body temperature, immunity, body awareness, and relaxation; decreases in discomfort, fatigue, tension, and stress levels.

General Contraindications: Medical emergencies (shock, hemorrhage, seizure, poisoning, etc.), high fever (102°F), highly-metastatic cancer, intoxication, pain medications or extreme fatigue (mental or physical).
Any **Client under physicians' care must notify therapist of condition and changes. Working without physician approval may be detrimental to the physical well-being of the client.

Rates: $95/ hour, **$120**/ 75-minute, **$135**/ 90-minute ~ Base Rates (discounts/packages available). Payment is due when service is received. Advance payment will be accepted. Cash and credit cards accepted and preferred. On occasion, checks are accepted. A fee of $25 will be charged on any returned check.

Confidentiality: All information/conversation exchanged during a treatment session or about a treatment session remains confidential for the safety and well-being of **Client** and **Therapist**.

General Etiquette:
-Late **Clients** will have a shortened treatment at the same rate of a full session.
-No shows will be charged for a full treatment session.
-Cancellations one day (24 hours) prior will not be charged - Less notice is charged 50%.
-Intoxication can have many negative effects on the body when combining Bodywork with alcohol.
-**Client** will be asked to leave and charged full price for a treatment session if found to be intoxicated or high.

Recommendations: Avoid large meals 90 minutes before a session. Food fresh in the system may have an adverse effect on the client. For TUI NA and Reflexology treatments, plan on having time after session for low-key activity or sleep. Contact lenses may become "dry" during treatment session, bringing a case is suggested.

Right of Refusal: **Therapist** and **Client** both reserve the right to end a treatment session at any time for any reason. Therapist will fill out a disclosure statement to inform client why treatment session is ending.
Client does not need to give any reason for ending a treatment session.
Sexual innuendos, language and/or behavior will not be tolerated. Session will end immediately and **Client** will be charged full price.

Name _____

Signature: _____

Date: _____

Confidential Health History

Name _____ □ Male □ Female Date of Birth _____

SECTION 1
Mailing Address _____
City _____State _____ Zip Code _____
Home Phone _____ Cell Phone _____Email_____

In **Case of Emergency**, who should be notified?
Name _____Relation _____ Phone_____
How did you hear about us? _____

SECTION 2
Occupation_____ How long? _____

Common Physical Activities: Which activities are you involved in? **NOTE:** (**w**)eekly or (**d**)aily basis.
___Standing (How long?_____) ___Desk Sitting (How long?_____) ___Sitting in a car (How long?_____)
___Aerobics ___Bend/Lift ___Computer work ___ Crossfit ___Cycle ___Hike/Walk ___ Jog/Run ___Martial Arts
___Pilates ___Skiing ___Swimming ___Tennis ___Weight Lifting ___Yoga/Stretch Other:_____

Are you **Pregnant**? (wks_____) (Due Date_____)
When was your **last therapy** session? _____
Do you have **allergic reactions** to any oils, lotions or other substances applied to your skin? □ **Yes** □ **No**
If yes, explain_____
How much **water**, per 8oz glass, do you drink per day (on average)? □ 2 □ 4 □ 6 □ 8 □ 10 □ 12+

What is your **overall purpose** for seeking Therapeutic Bodywork? (Check all that apply)
□ Stress Management □ Injury Prevention □ Injury Recovery □ Pain Management
□ Other _____

Please tell us about your **general health conditions**: **CIRCLE (C)**urrent or **(P)**ast

C P AIDS/HIV	**C P** Digestive	**C P** Muscle Spasms
C P Arthritis	**C P** DVT/Blood Clots	**C P** Nerve Damage
C P Bladder/Kidney	**C P** Endocrine/Thyroid	**C P** Numbness/Tingling
C P Blood Pressure H/L	**C P** Headaches/Migraines	**C P** Osteoporosis
C P Bruise Easily	**C P** Head Injury/Whiplash	**C P** Recurrent Infections
C P Bulging Disk	**C P** Insomnia	**C P** Skin
C P Bursitis	**C P** Jaw Pain/Teeth Grinding	**C P** Sinus
C P Degenerative Spine	**C P** Joint Pain	**C P** Surgeries
C P Depression/Anxiety	**C P** Lung	**C P** Tendonitis
C P Diabetes	**C P** Lymphatic	**C P** Varicose Veins

NOTES: _____

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