INFORMED CONSENT FOR BODYWORK

Name: _____ Date: _____

Phone: _____ DOB: _____ Email: _____

Emergency Contact: _____ Emergency Contact Phone #: _____

Health: (Circle or place a X next to All That Apply/Explain Below)

Allergies	Breast Implants	Covid 19 Vaccination	High/Low Blood Pressure
Arthritis	Bruise Easily Cancer	Currently Pregnant	Seizures
Back Pain	Cardiac Problems	Headaches	Suffer from Stress

Surgeries _____

Other _____

Describe what you're here for (i.e. chronic or acute pain, injury and how long injured, etc...)_____

_____

_____

How is your current emotional state? Any anxiety, depression, sleep issues, etc...?_____

_____

_____

Fitness Routine/Self Care Practices (please list activities you participate in and how many times per week)

_____

_____

What is your intention for your session?_____

_____

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

I understand that the bodywork I receive is provided for the basic purpose of relaxation and/or 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 bodywork should not be construed as a substitute for a medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailments that I am aware of. I understand that bodywork practitioners cannot 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 bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known 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 forget to do so. It is also understood that any illicit or sexual suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. **PAYMENT PREFERRED FOR SERVICES IS CASH, CHECK, VENMO OR ZELLE. THERE IS A $25 FEE FOR ANY CHECK RETURNED FROM THE BANK. A 72 HOUR CANCELLATION POLICY: IF YOU ARE UNABLE TO GIVE SUFFICIENT NOTICE TO CANCEL OR CHANGE AN APPOINTMENT (72 HOURS MINIMUM) YOU WILL BE RESPONSIBLE FOR THE FULL FEE FOR THAT APPOINTMENT**.

I HAVE READ AND AGREE TO THE TERMS OF THE INFORMED CONSENT AND CANCELLATION POLICIES AS LISTED ABOVE. PAYMENT IS DUE AT THE TIME OF BOOKING THE SERVICE.

Client Signature: _____ Date: _____