

## THERAPEUTIC AGREEMENT

I, \_\_\_\_\_ understand that the body therapy given here is for the purpose of promoting: natural structural balance, pain reduction, relief of muscular tension or spasm, stress reduction, and increasing circulation.

I understand that the therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the therapist does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulation. I understand the services are designed to be a health aid and are in no way to take the place of doctor's care when it is indicated. Information exchanged during any sessions is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion.

Because a therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my physical needs.

I will indicate to the therapist anything that makes me feel uncomfortable. I understand that either I, or the therapist, have the right to terminate a session.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CONSENT TO TREATMENT OF A MINOR

By my signature below I hereby authorize the Natural Reflex Practitioner to administer body therapy to my child or dependant, as they deem necessary.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## POLICIES & FEES

### **Cancellation**

Clients must cancel appointments 24 hours in advance. Appointments canceled less than 24 hours must be paid in full. Failure to pay for missed appointments will result in no future appointments.

### **Appointment time**

Sessions run approximately 50 minutes for an hour and 25 minutes for a half hour.

### **Payment**

Payment is due at the end of each session. We do not participate in any medical insurance plans. A \$25.00 fee will be charged for checks returned by the bank.

### **Prices for Sessions**

Please see price sheet.

**I have read the above policies and understand them clearly.**

Signature \_\_\_\_\_ Date: \_\_\_\_\_

## ADDITIONAL HEALTH INFORMATION

Are you currently taking any medications or supplements?

<input type="checkbox"/> Birth Control <input type="checkbox"/> Aspirin/ibuprofen/etc. <input type="checkbox"/> Antibiotics	<input type="checkbox"/> Diuretics <input type="checkbox"/> Vitamins/supplements <input type="checkbox"/> Other: _____
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Are you currently being treated by a physician for any condition?  Yes  No Please explain:

Are you pregnant or nursing?  Yes  No

Do we have your permission to contact your physician should the need arise?  Yes  No

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

How would you describe your overall level of stress?  
 Low  Medium  High

In the past year, have you experienced emotional trauma?  
 Yes  No Explain:

Are you wearing contact lenses?  Yes  No

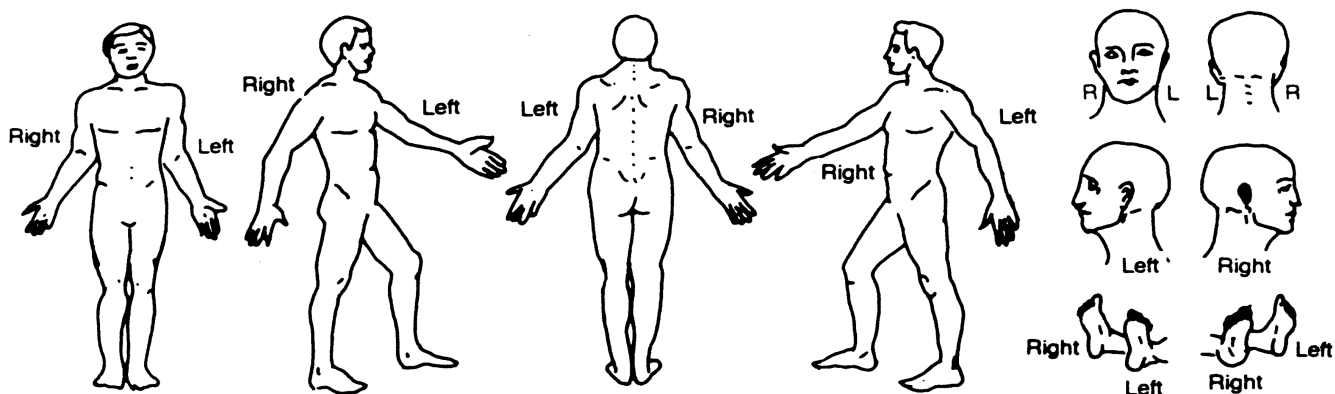
Do you have a pacemaker?  Yes  No

Orthopedic device in shoes?  Yes  No

Do you wear hearing aids?  Yes  No

Do you exercise regularly?  Yes  No

**PLEASE CIRCLE ALL AREAS YOU WISH TO BE ADDRESSED AND  
CROSS OUT ANY AREAS YOU WISH TO BE AVOIDED.**



### PLEASE CHECK TYPE OF THERAPY

<input type="checkbox"/> Natural Reflex Therapy	<input type="checkbox"/> Swedish Massage Therapy	<input type="checkbox"/> Deep Tissue Massage Therapy
<input type="checkbox"/> Hot Stone Massage Therapy	<input type="checkbox"/> Prenatal Massage Therapy	<input type="checkbox"/> Sa Wan Thai Herbal Therapy

### PLEASE READ AND AFFIRM BY INITIALING

I understand that breast massage will not be performed during my treatment.

I understand that for massage techniques complete draping will be used throughout my session.

I will voice any concerns to my therapist immediately if pressure, pain, heat sensitivities or any other comfort issues arise during my session.

# INTEGRATIVE HEALING INSTITUTE

## CLIENT INTAKE FORM

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Referred by: \_\_\_\_\_ In case of Emergency: \_\_\_\_\_ Telephone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Age: \_\_\_\_\_ Male ( ) Female ( ) Marital Status: \_\_\_\_\_

What is the primary reason for today's appointment?

What has been your previous experience with body therapy or other alternative or complimentary therapies?

SYMPTOMS AND CONDITIONS		
Abdominal Pain Allergies Arthritis Asthma Auto Accident Auto Immune Illness Back Pain Blood Clots Broken Bones Cancer Carpel Tunnel Chronic Pain Circulation Problems Cold/Flu/Fever Colitis Constipation Coccyx Injury Contagious Diseases Depression/Grief Diabetes Difficult Labor Dizziness or Vertigo Edema Epilepsy or Seizures Fainting Fatigue Fibromyalgia Syndrome Headaches or Migraines Heart Problems Herniated Disk Hormonal Problems	High Cholesterol HIV/AIDS Hysterectomy Joint Replacement Kidney Ailment Knee Surgery Liver Ailment Low or High Blood Pressure Neck Injury or Whiplash Nervousness Osteoporosis PMS Syndrome Pregnancy Respiratory Illness Sciatica Scoliosis Sensitivity to Heat/Cold Sensitivities to Other _____ Sinus Congestion Skin Disorders Sleep Disorder Spinal Injury Sprains, Falls or Stitches Stroke Surgery Thyroid Problem TMJ Ulcer Varicose Veins Other: _____	<p><b>If you have had any of the conditions to the left please <u>circle</u> and explain.</b></p>