Reflexology/Energy Work Waiver and Consent Form

Thank you for choosing Natural Wellness Centre for your reflexology/energy work therapy! It is our goal to provide you the most therapeutic experience possible. Please answer the questions below so that we can thoroughly address your needs. Rest assured that your information is confidential. Our therapists would like to hear your questions, comments, and complaints! We invite you to share them with your therapist in the way most comfortable for you; either in person, over the phone, or by e-mail! If you would like to see your therapist's license, please let us know.

Personal Information

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____
Birth Date: ___/_____/_____ Email: _____
Emergency Contact: _____
Emergency Phone: _____

Check Appropriate Items

Do you wear: □A Hearing Aid? □Contacts? □Dentures? □Pacemaker?

In which part of your body do you experience stress? □Leg □Neck □Shoulders □Back □Head

Is your stress level: □Light? □Moderate? □Heavy?

List injuries **not requiring surgery** that occurred within the past 2 years (i.e., broken bones, torn ligaments, auto accident)_____

Please list all medications you currently take (include over-the-counter medications as well as vitamins/herbs)_____

Are you sensitive to touch in any areas?_____
Do you have any nut allergies?_____

Please look over the list of health disorders and check all that apply.

□Bone or Joint Disease
□Rashes
□Broken/Fractured Bones
□Constipation
□Low Back/Hip/Leg Pain
□Headaches/Head Injuries
□Spasm/Cramps
□Sprains/Strains
□Varicose Veins
□Diabetes/Type?___
□High/Low Blood Pressure
□Drug/Alcohol Disorder
□Breathing Difficulties
□Nicotine/Caffeine Addiction
□Fibromyalgia/Myofascial Pain Syndrome
□Allergies
□Bursitis
□Warts
□Neck/Shoulder/Arm Pain
□Irritable Bowel Syndrome
□Herpes/Shingles
□TMJ/Jaw Pain
□Depression
□Cancer/Tumors
□Infectious Diseases
□Eating Disorder
□Sinus Problems
□Heart Conditions/Disease
□Chronic Pain
□Tendonitis
□Athletes Foot
□Arthritis
□Diverticulitis
□Fatigue
□Sleep Disorder
□Anxiety
□Endometriosis
□PMS/PMDD
□Lymphedema
□Bruise Easily
□Blood Clots
□Asthma

If you checked any disorders or diseases above, please use the next few lines to explain. (Example: dates, areas of disorder/disease, type, symptoms of concern. Please be specific.)_____

Is there anything else about your health history that you think would be useful for the Reflexology practitioner to know to plan a safe and effective session for you?_____

_____

Have you ever received Reflexology therapy before? □Yes □No If yes, when was your last?_____/_____/_____

What are your goals for this session? □De-stress □Injury Rehabilitation □Maintenance □Other:_____

Do you have difficulty lying on your front, back, or side? □Yes □No If yes, please explain:_____

_____

The purpose of this page is to clarify your financial responsibilities so that we focus our efforts on helping you achieve your optimal results in the shortest amount of time.

Our office requires 24-hour notice cancellation of appointments. Appointments missed or cancelled without sufficient notice will be charged the cost of treatment.

I consent to charge my credit card #:_____expiry date:_____for missed appointments.
Patient signature:_____

Late Arrivals
If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, **you will be responsible for the "full" session.** Out of respect and consideration for your therapist and other customers, **please** plan accordingly and be on time.

If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that reflexology 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. Because reflexology 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. **This is therapeutic reflexology and any sexual remarks or advances will terminate the session and you will be liable for payment of the scheduled treatment. I understand the Reflexology practitioner reserves the right to refuse services to me for any reason that she deems necessary._____(Initials)**

Male and female genitalia and women's breasts will not be exposed or touched at any time. Draping will be used during the session and only the area being worked on will be uncovered._____**(Initials)**

Informed written consent must be provided by a parent or legal guardian for any client under the age of 17.

Signature of Client:_____Date:_____/_____/_____

Signature of Reflexology Practitioner :_____Date:_____/_____/_____

We look forward to serving you!