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ADeVoe,LMT,LLC

CranioSacral Therapy
Manual Lymphatic Drainage Therapy

CLIENT INFORMATION AND CONSENT TO TREAT

Name:	Date of Birth:	Today's Date:

Preferred contact method for scheduling / appointment confirmation. Number these in order of preference and supply appropriate email address or number.	(order of Preference) Number / email address ____ Phone _____ ____ Email: _____ ____ Text: Message: _____

Primary Reason for Appointment / Areas of Pain or Tension:

Do you have previous experience with:

_____ CranioSacral therapy _____ Manual Lymphatic Therapy

Please mark:
(X) all conditions that apply now. ***(P) past conditions.***

	headaches, migraines		chronic pain		fatigue
	vision problems, contact lenses		muscle or joint pain		tension, stress
	hearing problems, deafness		muscle, bone injuries		depression
	injuries to face or head		numbness or tingling		sleep difficulties
	sinus problems		sprains, strains		allergies, sensitivity
	dental bridges, braces, dentures		arthritis, tendonitis		rash,
	jaw pain, TMJ problems		cancer, tumors		infectious diseases
	osteoporosis		spinal column disorders		blood clots
	constipation, diarrhea		diabetes		varicose veins
	hernia		pregnancy		high / low blood pressure
	IUD birth control		heart, circulatory problems		do you bruise easily
	abdominal or digestive problems		epilepsy or seizures		other medical conditions not listed

Current Medications, including aspirin, ibuprofen, herbs, vitamins, etc:

- I understand massage should not be performed under certain medical conditions and I affirm I have stated all my known medical conditions and answered all questions honestly.
- I agree to keep my practitioner updated as to any changes in my medical profile and there shall be no liability on the practitioner's part should I fail to do so.
- I understand that by signing this, I am giving consent to receive massage/bodywork from *A. DeVoe, LMT, LLC.*
- I understand I have the right to refuse, modify or terminate treatment, regardless of prior consent for such treatment.
- I understand that if I experience any pain or discomfort during the session, I will immediately notify the practitioner so pressure and/or strokes may be adjusted to my level of comfort.
- I understand treatments should not be construed as a substitute for medical care from a qualified physician or medical specialist for any mental or physical ailments I may have.
- I understand that massage practitioners are not qualified to perform medical treatment and nothing said during the session should be construed as such.
- I understand 24-hour notice is required to cancel a scheduled appointment. I understand if I fail to give 24 hours' notice of an appointment, I will be liable for full payment of the scheduled appointment.

Signature: _____ **Date:** _____