CLIENT INFORMATION

Name:________________________________DOB:______________Gender:________________

Address:____

Phone:________________________________Cell:______________________________________

Email:_________________________________Referred:_________________________________

In case of emergency:_________________________Phone: __________________________

GENERAL & MEDICAL INFORMATION:

Have you ever experienced any Personal Awareness, Bodywork, CraniosacralTherapy, Continuum &/or Somatic Movement sessions before?_____If yes, how recently?

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Please circle **Y for Yes** or **N for No** for any of the following conditions or symptoms, which apply to you now or in the past:

Y or **N** High Blood Pressure
Y or **N** Blood Clots
Y or **N** Heart Attack/Stroke
Y or **N** Low Blood Pressure
Y or **N** Varicose Veins
Y or **N** Muscle Strain/Sprain
Y or **N** Numbness or Tingling
Y or **N** Epilepsy or seizures
Y or **N** Sharp or stabbing pain

Y or **N** Low Back Pain
Y or **N** Arthritis
Y or **N** Hypo/Hyperglycemia
Y or **N** Varicose Veins
Y or **N** Osteoporosis
Y or **N** Stress or Anxiety
Y or **N** Bruise easily
Y or **N** Diabetes
Y or **N** Headaches

Y or **N** Joint swelling
Y or **N** Pregnant
Y or **N** Contagious Conditions
Y or **N** Surgeries
Y or **N** Allergies
Y or **N** Cardiac problems
Y or **N** Circulatory problems
Y or **N** Tension or soreness
Y or **N** Hallucinations

Please explain any of the above or other conditions/symptoms you have experienced:

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If you have had any serious or chronic illness/operations/traumatic accident, please explain:

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Do you have any history of surgeries, including dental? Please explain:

Is there a history of depression and/or anxiety?

Have you been treated or hospitalized for mental health issues? Please explain with current treatments:

Are you taking any medications? **Y or N** Please list below:

If you have children, list your child-bearing or child-raising history:

Positive Impact History: Note people and things that either currently or in the past have supported and affirmed you in your life:

CLIENT CONSENT AND WAIVER FORM

Please initial each statement then sign and date below:

______I understand that Body of Wonder personal or group sessions, such as Craniosacral Therapy, Massage Therapy, Continuum, Somatic Movement and Flow Awareness™ work with the body and individuals natural & innate healing wisdom which is considered Health; for an improved sense of wellbeing, integration, energy flow and quality of life.

______I understand that I am totally in charge of my experience and that should anything feel inappropriate, I will say so. The purpose of the session is for me to access my own innate inner healing wisdom and Health, to achieve a new balance, greater awareness and optimal functioning in life.

______I understand that the practitioner educator does not diagnose illness, disease, or any other physical or mental disorder. The practitioner educator does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations. It has been made very clear that Body of Wonder personal or group sessions, Craniosacral Therapy, Massage Therapy, Continuum, Somatic Movement and Flow Awareness™ sessions are not substitutes for medical examination or diagnosis is recommended that I see a medical practitioner for any physical or mental health ailment that I may have.

______I understand that services offered today, and in the future are not a substitute for medical care and that any information provided by the therapist is for educational purposes **only** and is **not** diagnostically prescriptive in nature.

______ I have stated all of my known medical and health conditions on the Client *I*nformation Form. I have consulted a medical doctor or licensed medical health care practitioner regarding any checked or described conditions.

______I realize it is solely my responsibility to keep the practitioner educator updated on any changes in my physical health and I understand that the practitioner educator, shall not be liable should I fail to do so.

______I understand that all Body of Wonder personal or group sessions, Craniosacral Therapy, Massage Therapy, Continuum, Somatic Movement and Flow Awareness™ services offered are strictly non-sexual. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I will be liable for full payment of the scheduled appointment or classes, there will be no refunds.

______By signing this release, I hereby waive and release Prue Jeffries, the practitioner/ educator, of any and all liability, past, present, and future, relating to Body of Wonder personal or group sessions, Craniosacral Therapy, Massage Therapy, Continuum, Somatic Movement and Flow Awareness™. In addition, I agree to indemnify and hold them harmless from and against any and all claims, demands, fines, suits, actions, orders, or damages of any kind which may arise or result out of or from my utilization of services.

I have received the policy statement, and have read and agree to the policies therein:

Client Name:____________________________Parent/Guardian **Name:**__________________

Client Signature:____Date:_____________

Consent to treatment of a minor: By my signature below, I hereby authorize Prue Jeffries dba Body of Wonder To administer Body of Wonder personal and/or group sessions, Craniosacral Therapy, Massage Therapy, Continuum, Somatic Movement and Flow Awareness™ sessions to my child or dependent as they deem necessary.

Signature of Parent or Guardian**:**________________________________Date:_____________