CLIENT INFORMATION AND RELEASE FORM

Name: _____DOB: _____Gender: _____

Address: _____

Phone: _____ Cell: _____

Email: _____ Referred by: _____

Emergency contact: _____ Phone: _____

GENERAL AND MEDICAL INFORMATION:

Have you ever experienced any Holistic Awareness, Bodywork, Craniosacral Therapy, NAIO™ &/or Somatic Movement Education/Therapy before? If yes, how recently? What was your experience?

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 Joint swelling	Y or N Arthritis
Y or N Low Back Pain	Y or N Surgeries	Y or N Bruise easily
Y or N Head Injury/ Concussion	Y or N Osteoporosis	Y or N Stress or Anxiety
Y or N Hypo/Hyperglycemia	Y or N Diabetes	Y or N Headaches
Y or N Epilepsy or seizures	Y or N Pregnant	Y or N Contagious Conditions
Y or N Sharp or stabbing pain	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:

If you have had any serious or chronic: Illness/ Operations/ Traumatic accidents, please explain:

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

Do you have a history of depression and/or anxiety? Please explain. Include any treatments that you find supportive.

Have you been diagnosed, treated or hospitalized for mental health issues? Please explain. Include any current treatments and relevant dates.

Are you taking any medications (over-the-counter or prescriptions). Please list below.

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

Resource and Positive Impact History: Please share people, activities, or things that have supported and affirmed you in your life in the past and present:

CLIENT CONSENT AND WAIVER FORM

Please initial each statement then sign and date below:

_____ I understand that personal or group sessions, such as Craniosacral Therapy, NAIO™ Somatic Movement Education & Therapy or 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 personal or group sessions, Craniosacral Therapy, NAIO™, Somatic Movement Education and Therapy sessions are not substitutes for medical examination or diagnosis. It 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 my known medical and health conditions on the Client Information 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 personal or group sessions, Craniosacral Therapy, NAIO™, Somatic Movement Education and Therapy 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 *dba* Body of Wonder, Surf the Flow and NAIO International, of any and all liability, past, present, and future, relating to personal or group sessions, Craniosacral Therapy, NAIO™, Somatic Movement Education and Therapy. 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.

Client Name: _____ Parent/Guardian Name: _____

Client Signature: _____ Date: _____

Consent to treatment of a minor: By my signature below, I hereby authorize practitioner/educator to administer personal and/or group sessions, Craniosacral Therapy, NAIO™, Somatic Movement Education/Therapy sessions to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____