CLIENT CONSULTATION FORM

To ensure your well-being and for my records, I require all clients to complete and sign this form before each treatment.

I will privately store the information that you provide on this form according to the Data Protection Act. In addition I may take notes of the information that you provide and/or which I will observe during the treatment.

Client Name: _____

Phone: _____ Email:_____

Home address: _____

	Do you suffer from any of the following? Tick if the answer is YES, more will be discussed
	Dizzy spells and sudden nausea
	Allergies – if YES describe below
	Epilepsy
	Scoliosis
	Any degenerative conditions – if YES describe below
	High Blood Pressure
	HIV/AIDS
	Currently pregnant
	Given birth in the last 6 months
	Surgery in the last 6 months – if YES describe below
	Taking antidepressants, blood thinners or any prescription medications
	Any persistent numbness or tingling in limbs
	Any tightness in the chest area that makes it difficult to breathe
	Anything else you wish to privately discuss prior to your treatment

	I confirm I <u>am not</u> under the influence of alcohol or recreational drugs at the time of my treatment and in the 24 hours prior to my treatment I have not been drinking or using drugs
	YES, I confirm

Client Waiver – Please read each of the following statements to confirm understanding and acceptance:

I understand and agree that the Therapist is solely responsible for the treatment;

The Therapist offers therapeutic treatments for which he/she is fully qualified and insured (all certifications are available for you to view on request);

I understand and agree that I will incur in full charges if I cancel without 24 hours' notice or if I arrive later than 15 mins to my appointment I won't get the full time I booked;

I understand that the services offered today are not a substitute for medical care and that prior to my treatment; I have informed the Therapist of all known medical conditions and injuries;

I agree to inform the Therapist of any changes in my health and medical condition during my treatment. I understand there shall be no liability on the Therapist's part if I forget to do so;

This release and any disputes or claims arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) are governed by and construed in accordance with the laws of England and Wales and the English Courts shall have exclusive jurisdiction;

COVID-19 DISCLAIMER

I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment, therefore I confirm that:
I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
I have not travelled internationally within the last 14 days to any high risk areas.
I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non contagious by state or local public health authorities.
I am following all recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.
By signing this release, I hereby waive and release my Therapist from any and all liability, past, present, and future relating to the massage therapy undergone today.

Client Signature _____ Date: ____/____/_____