CONFIDENTIAL CLIENT INFORMATION

Your Personal Details

Name: _____
Address: _____
Home Phone: _____ Mobile : _____
E-mail: _____
Postal address: _____
Date of Birth: _____
Emergency Contact Person: _____
Phone: _____
How did you learn about us? _____
Are you currently under a physician's care for an acute or chronic illness? Y _____ N _____
If yes please explain:

_____

If yes, who is your health care provider (some of our services may be claimable):

_____

Are you currently taking any prescribed medication or dietary supplements?
Y _____ N _____
If yes please provide details:

_____

Occupation: _____
Physically related work duties: (eg computer work, heavy lifting, standing, etc

_____

Have you received a massage before? Y__ N__ If yes, when: _____
How did you hear about us? (If it is one of our clients – please tell us their name as we would like to thank them)

_____

What are your expectations from this session:

_____

Please list areas of tension, stress and/or pain you wish to be addressed:

_____

_____

Health Information

Please mark an (X) by all current conditions and (P) for all past conditions

__ Abdominal /digestiveproblems
__ Arthritis/tendonitis
__ Blood clots
__ Constipation/diarrhea
__ Dizzy spells
__ Hearing problems
__ Jaw pain/TMJ pain
__ Muscle/joint pain
__ Rash/fungus
__ Spinal disorders
__ Vision problems
__ Other

__ Allergies
__ Asthma, respiratory, or lung condition
__ Chronic pain
__ Depression
__ Fatigue
__ Hernia
__ Low blood pressure
__ Numbness/tingling
__ Sinus problems
__ Sprain/strain
__ Varicose veins

__ Anxiety
__ Circulatory/heart problems
__ Diabetes
__ Headaches, migraine
__ High blood pressure
__ Muscle/bone injuries
__ Pregnancy
__ Sleep difficulties
__ Tension/stress
__ Menopause

If you answered yes to any of the above, please provide details:

_____

_____

Please list any recent injuries or surgeries within the past 5 years:

_____

_____

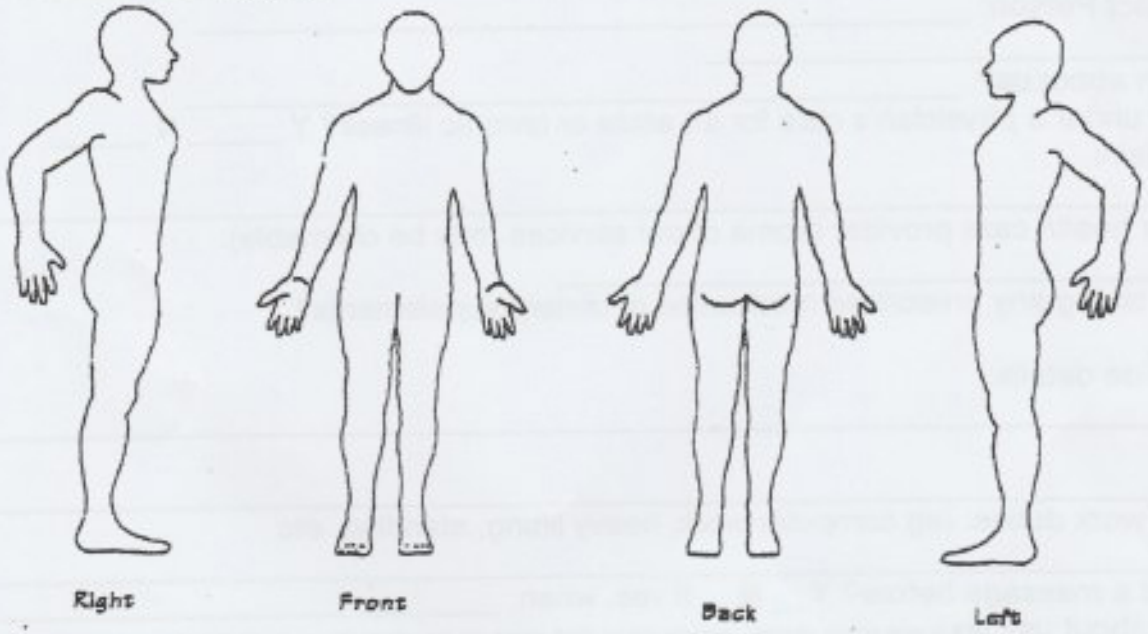
PLEASE COMPLETE REVERSE SIDE OF FORM

Please list your relaxation activities, hobbies, exercise and/or sport participation:

_____

Please use the letters provided in the key to identify the symptoms you are feeling today. Circle the area around each letter, representing the size and shape of each symptom location.

P= pain or tenderness
S= joint or muscle stiffness
N= numbness or tingling



Client Commitments

I declare that the information I have provided on this form is to the best of my knowledge true and accurate and that I have not intentionally withheld any information relevant to my treatment. I understand that any therapy provided to me by the practitioner does not constitute medical treatment. If I am unable to attend my scheduled appointment, I will respect and abide by the set cancellation policies.

Client Signature: _____
Date: _____

I ACKNOWLEDGE AS A NEW CLIENT AT FOUNTAIN OF YOUTH AND FLOAT CENTRE THAT IF I DO OT SHOW FOR AN APPOINTMENT I WILLINCUR A 50% FEE, OR, IF I CANCEL UNDER 24 HOURS I WILL INCUR A FEE OF 25%.

Therapist Commitments

As a professional therapist I make the following comments to you:

- *I shall care for your health, well-being. comfort and ease with the utmost skill appropriate to my current qualifications.*
- *I shall protect your privacy, modesty. and morality with the utmost honour, dignity and respect.*
- *If I find that your needs are outside my range of training I will immediately recommend you to a more appropriate therapist.*
- *I shall treat with utmost confident the contents of the Client Information Form and any other information you choose to share with me during therapy sessions.*
- *A copy of any records kept by my concerning you and the therapy sessions I provide you will be made available to you, upon a written request signed by you.*
- *If I am unable to keep a previously booked session I still strive to provide you with at least 24 hours' notice. If I am unable to do this I will offer you are replacement session at half price or less.*