Client Intake & Medical History

Micro-current Point Stimulation

CLIENT INFORMATION

Name		D.O.B.
Address		
City	State	Zip Code
Phone	Occupation	
Email		
Emergency Contact		Phone

Height: ____________ Weight: ____________

Do you exercise regularly?	☐ Yes	☐ No	☐ How often? ____________
Do you follow a specific diet?	☐ Yes	☐ No	☐ Which diet? ____________
Do you consume alcohol?	☐ Yes	☐ No	☐ How often? ____________
Do you smoke?	☐ Yes	☐ No	☐ How often? ____________
Do you drink water daily?	☐ Yes	☐ No	☐ How much? ____________

Are you experiencing pain on any part of your body? ____________

____

What are your concerns? ____________

____

What are your goals? ____________

____

____

FEMALE CLIENTS ONLY

Are you pregnant or nursing?

____

MEDICAL HISTORY

Please check all that apply

☐ Anticoagulants	☐ Eczema	☐ Hives/Herpes/ Shingles	☐ Muscular Dystrophy	☐ Seborrhea
☐ Arthritis	☐ Electrical Implants	☐ Hormone Therapy	☐ Neurological Disorder	☐ Sinus Infection
☐ Asthma	☐ Epilepsy	☐ Hypertension	☐ Numbness	☐ Skin Cancer
☐ Autoimmune Disease	☐ Fever	☐ Infection	☐ Osteomyelitis	☐ Sunburn
☐ Bleeding Disorder	☐ Gynecological Issues	☐ Inflammation	☐ Pacemaker	☐ Thrombosis
☐ Breastfeeding	☐ Headaches/ Migraines	☐ Internal Bleeding	☐ Phlebitis	☐ Thyroid Disease
☐ Cancer	☐ Heart/Liver/ Kidney Disease	☐ Joint/Muscle Pain	☐ Plastic/Bone Cement/ Metal Implants	☐ Transplant/s
☐ Cardiac/Vascular Issues	☐ Hemophilia	☐ Keloid Scarring	☐ Pre-Cancerous Lesions	☐ Tuberculosis
☐ Cognitive Issues	☐ Hemorrhage	☐ Loss of Sensation	☐ Pregnant	☐ Unhealed Wounds
☐ Dermatitis	☐ Hepatitis	☐ Low Blood Pressure	☐ Psoriasis	☐ Vascular Disease
☐ Diabetes	☐ Hernia	☐ Lupus	☐ Rashes	☐ Varicose Veins
☐ Digestive Issues	☐ High Blood Pressure	☐ Metabolic Disease	☐ Recent Surgery	☐ Other
☐ Dislocations	☐ HIV	☐ Muscle Cramps	☐ Respiratory Condition	______________ ______________

Details for any of the above ______________________________

Are you currently taking any medications, including oral, topical or transdermal? ☐ Yes ☐ No

Details ______________________________

Do you have any allergies? ☐ Yes ☐ No

Details ______________________________

____

This form is completely confidential. By signing below, I agree to the following:

The information I have provided regarding my Medical History is accurate to the best of my knowledge.

I understand the information given pertaining to the requested treatment/s and confirm that I do not have any condition/s that would make the treatment/s unsuitable.

I agree to inform my provider if I experience any discomfort during the procedure, so they may adjust accordingly.

I agree to waive all liability towards my provider and "UNRAVELED LLC" for any injury or damages incurred due to my failure to disclose any existing or past health conditions.

Client Signature ______________ Date ______________

Client Consent Form

MICRO-CURRENT POINT STIMULATION (MPS)

Micro-current Point Stimulation (also known as MPS) is very low level DC current that stimulates the body to heal itself by restoring the balance of the nervous system. It is non-invasive and is widely used as a all-natural/drug free way to treat chronic, acute soft tissue pain, and scar tissue.
Please read and initial the following:

I voluntarily elect to undergo this therapy, having had the nature and purpose of this treatment, along with the risks and hazards involved fully explained to me, by "UNRAVELED LLC".

I understand that this therapy is a complimentary therapy used to help relieve symptoms such as pain, restriction or stress.

I understand that to achieve maximum results, I may need further treatments. But I also understand there are no guaranteed results.

I understand there are certain contraindications to receiving MPS Therapy and I certify that I do not suffer from the following conditions:

- Metal Plates, Defibrillator or Pacemaker installed
- Cardiac or Vascular Disease
- Diabetes
- Cancer
- Epilepsy
- Bacterial infection
- Open wounds/Ezcema
- Sunburn
- Thrombosis
- Hemophilia

The information I have provided about my medical history is accurate to the best of my knowledge, including all known allergies and/or prescription drugs/products I am currently ingesting or using topically.

I confirm that I am not currently pregnant or breastfeeding.

I understand that this type of therapy is not used to cure any condition.

I hereby give my informed consent to proceed with Micro-current Point Stimulation. I have read and fully understand this agreement and all information detailed above.
I understand the procedure being performed today and accept all possible risks. I have had all contraindications and possible side effects of MPS therapy explained to me and my questions have been answered to my satisfaction.
I do not hold "UNRAVELED LLC" or the provider performing the procedure responsible for any and all liability associated with therapy whether past, present or future.. I consent to the terms of this agreement.

I confirm that I am at least 18 years of age and by signing this Consent Form, I agree to waive all liability towards my provider and "UNRAVELED LLC" for any injury or damages incurred due to any misrepresentation of my medical history.

NAME PRINTED **SIGNATURE** **DATE**

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