

BEACH LIFE WELLNESS INSTITUTE, LLC

Client Intake - Confidential Case History

Date____/____/____

Name____Phone____

Address____

Email____D.O.B. ____

Referred by____Primary concern for today's visit ____

First Noticed____Getting Worse____Constant____Comes & Goes____

Aggravated by____Interferes with: Work____Sleep____Daily Routine____

What have you tried to get relief? ____

Do you have any medically diagnosed condition?____

Have you had surgery recently?____

Do you take prescription medication?____

Physician____Phone____

Emergency Contact____Phone____

Please circle or check if you ever had a history of any of the following:

- | | |
|---|--|
| * Heart trouble / heart attack/ cardiovascular diseases | * Pains in heart or chest |
| * Stroke or cerebral hemorrhage | * Heart palpitations or irregular heartbeats |
| * Electronic devices/ pacemaker/ defibrillator/ other | * High blood pressure |
| * Blood thinning medication | * Open wounds/ psoriasis |
| * Abdominal, back, muscle, joint, bone concerns | |
| * Lung disease or shortness of breath/ Fainting spells or dizziness | |
| * Diabetes Type I or Type II | * Nervousness/ seizures/ numbness |
| * Have you ever had major surgery | * Pains in legs/ varicose veins |
| * Arthritis/ bursitis/ sciatica | * Hepatitis, HIV/AIDS, Cancer |
| * Are you pregnant | * Do you smoke, quit smoking, how many years____ |
| * Do you exercise regularly | * Allergies to oils and/or scents |
| * Are you presently taking any medication, sedative or supplements? | |

Please explain:

SIGNATURE_____

GENERAL LIABILITY WAIVER

I consent to use the facilities, services, and programs of **BEACH LIFE WELLNESS INSTITUTE, LLC**, including but not limited to massage therapy, fitness classes, martial arts, personal or group training, spine and joint programs, nutrition programs, skin care and aesthetic treatments, acupuncture, energy medicine, and any other wellness services offered.

I understand these activities involve inherent risks of injury, and I voluntarily assume all such risks associated with my participation or presence at the facility.

For myself and any minors for whom I am signing, I release **BEACH LIFE WELLNESS INSTITUTE, LLC**, its agents, employees, practitioners, and instructors from all liability for injuries, damages, or losses arising from participation in any services or activities. I agree to indemnify and hold harmless the same parties from any claims, damages, attorney's fees, or expenses related to my participation or use of the facility.

I authorize emergency medical transportation and treatment at my own expense. I acknowledge that the facility is not responsible for the safekeeping of my personal belongings.

I authorize **BEACH LIFE WELLNESS INSTITUTE, LLC** and its project sponsors to use and publish photographs or video of me, including my image, likeness, or voice, for lawful purposes such as promotion, advertising, or electronic publication. This authorization is perpetual unless revoked in writing.

This waiver applies to all future visits, activities, treatments, or services without requiring additional signatures. I acknowledge that I have read and agree to the facility's privacy policies.

GENERAL STATEMENT OF PROGRAM OBJECTIVES, RISKS, AND PROCEDURES

I understand that participation in fitness classes, personal or group training, spine decompression, exercise programs, and martial arts involves physically demanding activities that may cause stress, anxiety, physical injury, or other hazards. I acknowledge that these programs may include cardiovascular training, strength and resistance exercises, flexibility work, agility drills, calisthenics, and high-intensity conditioning. I understand that exercise may cause changes in heart rate or blood pressure and, although rare, may result in serious events such as heart complications, muscle strains, or other injuries. I recognize that individual reactions to exercise cannot be predicted. I consent to instructors, trainers, or coaches providing physical guidance to me or my minor child when necessary to correct form, improve technique, or reduce the risk of injury.

I understand that obtaining medical clearance before beginning any fitness or martial arts program is recommended. By signing, I acknowledge that I am doing so for myself and/or a minor, and that we are bound by the terms of this agreement. This agreement is binding on the participant's heirs, executors, next of kin, assigns, and personal representatives.

In consideration of the right to participate, I agree to indemnify, hold harmless, and release **BEACH LIFE WELLNESS INSTITUTE, LLC**, and its trainers, employees, faculty, staff, agents, instructors, practitioners, and all individuals assisting with the activity, from any liability for injury or death arising from or connected to my participation, whether caused by the alleged negligence of the facility, its staff, another participant, or any other cause.

This agreement applies to every day I participate in any fitness or martial arts activity without requiring additional signatures. I further agree to defend and indemnify **BEACH LIFE WELLNESS INSTITUTE, LLC** against any loss, damage, claims, or lawsuits related to personal injury, death, or property damage resulting from my participation or use of the facility or its equipment.

I represent that I am in satisfactory physical condition, have obtained medical clearance from my physician, and am ready to participate. I authorize any person connected with the activity or **BEACH LIFE WELLNESS INSTITUTE, LLC** to administer first aid as deemed necessary. I also confirm that I have read and fully agree to all terms stated in the "First Statement" at the beginning of this form.

INITIALS: _____

Massage Therapy, Skin Care, Facials

I agree to inform the practitioner immediately if I experience any pain or discomfort so that techniques, devices, or products can be adjusted. I understand that even light pressure or minimally invasive techniques may cause temporary soreness, redness, irritation, or bruising. I acknowledge that massage, facial, and advanced esthetic services may involve the use of various tools and techniques, including but not limited to hot stones, hot towels, heated bamboo sticks, dermaplaning blades, microneedling devices, nano infusion technology, and LED light therapy. I understand that these tools and devices can cause skin irritation, sensitivity, or burns even at lower temperatures or shallow depths.

I recognize that each person has different skin sensitivity and skin thickness, and that certain medications—such as blood thinners, retinoids, or photosensitizing medications—may increase the likelihood of bruising, irritation, hyperpigmentation, or prolonged healing. I understand that while such effects are often temporary, they may occasionally last for extended periods, including several weeks or months depending on the treatment.

I acknowledge that these services are not a substitute for medical examination, diagnosis, or treatment, and that practitioners do not diagnose, prescribe, or treat medical or mental health conditions. I affirm that I have disclosed all known medical conditions, medications, allergies, and recent skin procedures, and that I have answered all questions truthfully. I agree to update the practitioner about any changes to my health and understand they are not liable for issues arising from my failure to do so. I understand that practitioners may refuse treatment if they determine that a service is contraindicated for my condition.

I understand that any illicit or sexually suggestive remarks or behavior will result in immediate termination of the session. I voluntarily assume all risks associated with massage therapy, skin care, facials, microneedling, nano infusion, dermaplaning, and LED light therapy.

I confirm that I have read and fully agree to all terms stated in the “First Statement” at the beginning of this form.

Nutrition Coaching

I understand that Nutrition Coaching is not a personalized diet plan. Our nutrition and portion control plan is a general guide designed to help me make better food choices, read packaged food labels, and understand the nutritional value of the foods I choose to eat. I acknowledge that this guide includes a wide variety of foods, including but not limited to fruits, vegetables, meats, fish, poultry, grains, legumes, nuts, fats, oils, and fluids. I understand that the guide is intended to provide an appropriate calorie range for my needs, generally between 1,200 and 2,500 calories per day depending on my weight and activity level. I affirm that I am healthy, have no known food allergies, and that it is solely my responsibility to determine whether any suggested foods are safe for me. I understand that I have been advised to obtain medical clearance from my physician before using this guide, and that allergic reactions can cause minor or major complications, including potentially life-threatening reactions. I agree that the use of this nutritional guide is entirely at my own risk. I waive any claims of injury or damage and assume full responsibility for any allergic reaction, injury, loss, or death resulting from my use of this guide, whether due to my own negligence or the negligence of my nutritional coach. (If the client is under 18, a parent or guardian must also sign.)

I agree that my trainer, instructor, coach, and their stockholders, partners, and employees are not legally responsible to me, my family, or my heirs for any claims, injuries, damages, or death arising from or connected to my use of this nutritional guide. I fully and forever release all such claims, known or unknown, anticipated or unanticipated, resulting from my use or intended use of this guide or any advice provided by my nutritional coach. I confirm that I have obtained medical clearance from my physician to use this nutritional guide.

I also state that I have read and fully agree to all terms stated in the “First Statement” at the beginning of this form.

INITIALS: _____

Acupuncture and Oriental Medicine

I understand that treatment methods used in this practice may include acupuncture, herbal medicine, moxibustion, cupping, electrical stimulation, medical qigong, massage, gua sha, heat therapy, ear seeds, dietary guidance, qigong exercises, laser or LED therapy, microneedling, collagen/B12 or other injections, and lifestyle counseling. I acknowledge that acupuncture, microneedling, injections, moxibustion, electrical stimulation, cupping, and pricking are generally safe, but may cause temporary bruising, swelling, bleeding, numbness, tingling, or soreness lasting a few days and sometimes weeks. Less common risks include dizziness, fainting, nerve irritation, burns, blistering, scarring, pneumothorax, or infection, even though sterile, single-use needles and clean procedures are used. I understand that bruising or redness from cupping or gua sha is common and temporary. I acknowledge that no treatment or series of treatments is guaranteed to be effective, and that acupuncture supports natural healing but is not a substitute for medical diagnosis or care. Results may take time, especially for chronic conditions. I understand that certain habits or medications, such as alcohol, painkillers, steroids, narcotics, tobacco, antidepressants, or illegal drugs, may reduce treatment effectiveness. I will notify my practitioner if I am pregnant or trying to become pregnant.

I acknowledge that herbal and nutritional supplements are considered safe when taken as directed, but large or improper doses may be harmful. Some herbs are not appropriate during pregnancy or certain medical conditions. Possible side effects include nausea, stomach discomfort, vomiting, headache, diarrhea, rashes, hives, or tongue tingling. I agree to stop taking any herbs and notify my practitioner immediately if I experience adverse reactions. I understand that I may discuss risks and benefits further with my practitioner, but I do not expect them to anticipate every possible risk. I rely on their best judgment based on the information I provide. My participation and compliance with recommendations are essential to achieving the best outcome. I confirm that I have read and fully agree to all terms stated in the "First Statement" at the beginning of this form.

Cancellation Policy

I understand that missed appointments prevent other clients from receiving services and result in lost income for practitioners. For this reason, the credit card used to book my appointment will be automatically charged in full for any session not canceled at least 24 hours in advance. This policy is enforced with **NO EXCEPTIONS**. I acknowledge that it is my responsibility to keep my contact information current to receive appointment reminders. If I need to reschedule, I agree to cancel any conflicting appointments before booking a new time.

Release of Liability

I HAVE READ AND UNDERSTAND THIS RELEASE OF LIABILITY AGREEMENT AND VOLUNTARILY AGREE TO ITS TERMS. I am aware that I may ask questions at any time or discontinue participation in any activity or service. I acknowledge that I have been advised of the importance of obtaining medical clearance from a physician before participating in any services or programs offered by **BEACH LIFE WELLNESS INSTITUTE, LLC**, and I certify that I have been medically cleared to do so. In the rare event that any of the risks described above occur, I release **BEACH LIFE WELLNESS INSTITUTE, LLC** from all liability arising from my participation in these activities or services. I agree that neither I nor my heirs, assigns, or legal representatives will sue or make any claims against **BEACH LIFE WELLNESS INSTITUTE, LLC** or its employees for personal injury, property damage, loss, or wrongful death, whether caused by negligence or otherwise. I confirm that I have read and fully agree to this entire 3 page **General Liability Waiver** and all its terms and conditions.

NAME, DATE & SIGNATURE:
