Today's Date:_____ **CLIENT CONSENT FOR CARE & HISTORY**

Name: _____ **Phone: (H)**_____ **(W)**_____ **(C)**_____
Address: _____
City, State:_____ **Zip:**_____

Occupation:_____ **Employer:** _____ **Date of Birth:** _____ **Age:** ____

Referred By: _____ **Physicians Name:**_____

Previous Experience with Massage: _____ **Email:** _____

Please mark **(X)** all conditions that apply now. Put a **(P)** for past conditions

__headaches, migraines	__chronic pain	__fatigue	NOTES
__vision problems, contacts	__muscle or joint pain	__tension, stress	
__hearing problems, deafness	__muscle, bone injuries	__depression	
__injuries to face or head	__numbness or tingling	__sleep difficulties	
__sinus problems	__sprains, strains	__allergies, sensitivity	
__dental bridges, braces	__arthritis, tendonitis	__rash, athletes foot	
__jaw pain, TMJ problems	__skin cancer, tumors	__infectious disease	
__asthma or lung conditions	__spinal column disorders	__blood clots	
__constipation, diarrhea	__diabetes	__varicose veins	
__hernia	__pregnancy	__high blood pressure	
__birth control, IUD	__heart problems	__low blood pressure	
__abdominal or digestive problems	__hyper thyroid (high)	__fibromyalgia	
__circulatory problems	__ hypo thyroid (low)	__other medical conditions not listed	

Are you allergic to (**Y** or **N**): Peanuts___ , Macadamia Nut ___, Almonds ___, Lanolin ___, Aloe___,
__**Check Here if NO to all** Coconut ___, Grape seed___

Explain Any Areas Noted Above:_____

Current Medications: Including Chemotherapy oral/IV, Aspirin, Ibuprofen, Herbs, Vitamins, Etc.

_____

_____

Surgeries:_____

_____

Accidents: _____

Please list all forms and frequency of stress-reduction activities, hobbies, exercise, or sports participation:

_____

Patients having had a cancer DX, or other medical issues, Physician information:

__Cancer Diagnosis / Type: _____ Diagnosis Date: _____ __Chemotherapy __Radiation
__Lymph node removal: Where?_____ Number of Nodes:_____ Did you Receive PT? __Yes __No

Family Physician:_____ Surgeon:_____ Oncologist:_____
If I may contact your Physician for additional information, please sign below:
I give permission for Kriz Retsema, NCTMB, CLT, to obtain information that may be helpful with my lymphedema management, therapeutic/oncologic massage, and/or integrated care services.

_____ Client Signature:_____ Date:_____
Print Name

CLIENT CONSENT FOR CARE & HISTORY
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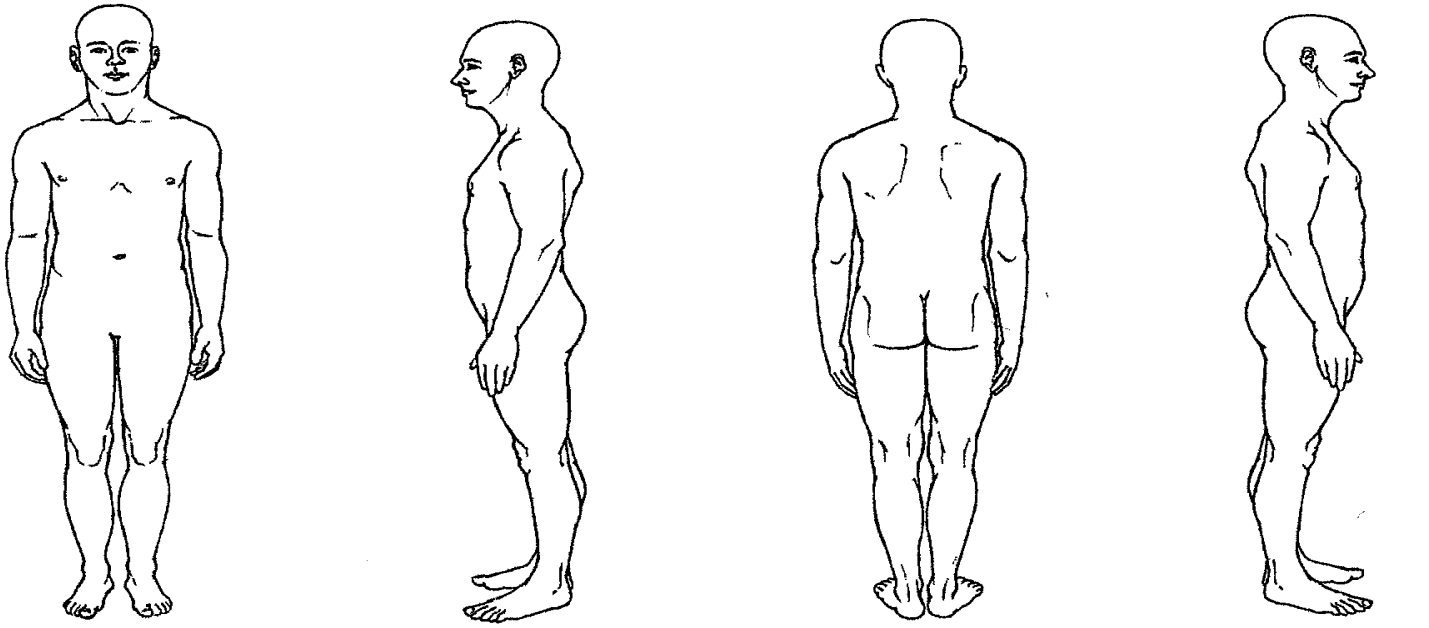
I understand that Shift Center practitioners do not diagnose medical, physical or mental disorders, nor do they perform spinal manipulations by the use of a thrusting force. I acknowledge that any therapies offered at the Shift Center are not a substitute for medical examinations or treatment; Shift Center services are complementary to medical care and services.

Cancellation & No show policy agreement: If you No Show and fail to cancel 24 hours in advance of your appointment your therapist will charge your account for the time intended. In the case of extenuating circumstances please feel free to discuss this matter w/ your therapist. Thank you for respecting our time and energy.

Primary Reason for Appointment, Areas of Pain or Tension Mark on Herbettes' body.



initials _____

Manual therapy is intended to help you learn more about the dynamics of health that are within your control—increased awareness of your patterns of movement and holding, responses to stress, and accumulation of tension. Manual therapy is a holistic approach to bridging mind and body. Together we will recognize your physical signals of diminishing health and enable you to respond to them in ways that promote vitality, balance, and spirit.

Circle services to be received today: **Time:** 30 minutes - 60 minutes - 90 minutes - 120 minutes

Massage Therapy:

Deep Tissue - Lymphatic - Swedish - Medical/Therapeutic - Oncologic - Pre or Post Natal

Lymphedema Treatment:

Initial Assessment & TX - Daily Acute Phase TX (CDT) - Follow up TX - Site specific w/ massage or other

Other: CranioSacral Therapy - Energy Exercises - Emotional Freedom Technique (EFT)
Heart Centered Therapy - Pre or Post Surgical - Positive Awareness - Reiki - Reflexology

Your expected outcome from today's work:_____

Thank you for your input. Clients Signature: _____ Date: _____

HAVE A GREAT SESSION !!!