TOUCH MODALITY CLIENT INTAKE FORM

_____
Date

Personal Details

_____ _____
Name Date of Birth

_____
Address

_____ _____ _____ _____
City/Suburb State Postcode Phone Number

_____ _____
Email Occupation

Emergency Contact

_____ _____ _____
Name of Emergency Contact Phone Number Relationship

Medical Details

_____
Current Doctor and phone number

_____
Medication, drugs (prescribed, not prescribed, recreational) currently or recently in use

_____
Past/present or recurring health conditions

_____
Are you pregnant? If so, how many weeks?

_____
If you are pregnant, are there any high-risk factors or complications?

_____
Do you have any allergies/sensitivities/injuries? If so, please detail above

_____
Please specify any surgeries

Please tick off any of the following that apply to you:

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney
- ☐ Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains

_____

Please explain any of the conditions you have marked above

Treatment Details

Please tick if you have undertaken any of the following treatments in the past:

- ☐ Acupuncture
- ☐ Massage
- ☐ Chinese Herbs
- ☐ Naturopathy
- ☐ Other (please state): _____
- ☐ Deep Tissue
- ☐ Reflexology
- ☐ Lymphatic Drainage
- ☐ Remedial Massage

_____

What were the results of the treatment(s)?

_____

Do you suffer from chronic pain (long term) or other?

_____

Type of pain or discomfort and what is its frequency?

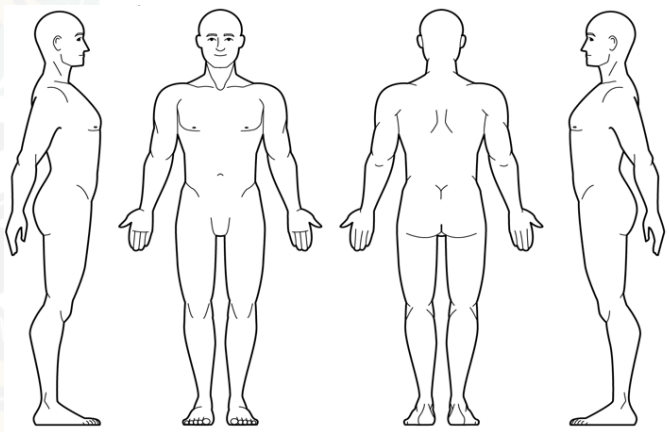
_____

Does the pain occur during a specific movement? Is the pain sharp, an ache, a shooting or dull, etc. pain?

_____

Are there any aggravating or relieving factors?

Please circle any areas of discomfort



History of presenting complaint (how it happened, position, direction, etc;)

What is your desired outcome or areas you would like to work with? (i.e. overcoming emotional/physical/mental or spiritual issues, goal setting etc.)

What obstacles do you think might get in the way of this outcome?

Have you received professional treatment or assistance for your concerns before? If yes, please specify

Please circle the following on a scale of 1(poor) – 5 (great)

Quality of Sleep	1	2	3	4	5
Energy Levels	1	2	3	4	5
Stress Levels	1	2	3	4	5
Nutritional Habits	1	2	3	4	5
Exercise Habits	1	2	3	4	5

Is there anything else that you think is important?

IMPORTANT: I agree that the above information is true and correct and hereby consent to treatment(s).
I have had the procedure explained to me and understand the nature of the treatment. I fully understand this treatment is not a substitute for medical treatment and it may take several sessions before I notice any benefit. This will depend on my lifestyle, ongoing medication and general health.

I agree that I take full responsibility for my health, and that I am committed to achieving my desired goal with my therapist. I acknowledge that my therapist adheres to non-discriminatory practices and guidelines.

Client Signature

Date

CLIENT CONSENT & WAIVER FORM

Please take a moment to read the following information and sign at the bottom of the page.

I have, following consultation, consideration and discussion, agreed to undergo this therapy. I am fully aware that the services I wish to receive are those of a holistic nature and do not serve as a substitute for professional medical advice, examination, diagnosis or treatment. I accept that no treatment guarantee can be given and it may take several sessions before I notice any benefit. This will depend on my lifestyle, ongoing medication and general health.

Summarised

- I understand treatment is of a holistic nature and does not serve as a substitute for professional medical advice, examination, diagnosis or treatment.

I understand that my treatment notes include my personal information and health history. Also documented will be any issues discussed, interventions, treatment planning, goals and progress. All records will be kept securely, and strict confidentiality is maintained. No authorisation of my notes will be released to anyone without my written consent unless required by law.

Summarised

- I understand my details are confidential unless I provide written authorisation, or they are required by law.

I am voluntarily undertaking these therapy services, whereby I understand when all care is undertaken by the therapist, I accept and assume all risk and responsibility. On behalf of myself, estate and all stakeholders I understand I am waiving my therapist and/or their business identity for all liability regarding injuries/damages that could possibly result from these services. I understand this waived liability also relates to any future claims of any kind that may result from undertaking these services in the future as long as these services are competently performed.

Summarised

- I understand and accept all responsibility for services received and herby waive and release my therapist and her associates from any liability past, present and future relating to these services.

Also

- I acknowledge that my therapist adheres to non-discriminatory practices and guidelines.

- I confirm that I have supplied my therapist with all known medical conditions, injuries and presenting issues. In the event I may have not then I understand that the therapist is not liable in any way

- I confirm that I will inform my therapist of
    - Any changes with my health in consideration for treatment planning
    - Any discomfort at the time of services/treatment or before and after session

- I understand that services and treatments are non – sexual and that only necessary physical contact (such as massage) will occur in treatment.

- I am committed to achieving my desired goal with my therapist.

By signing this form, I am consenting to treatment and I hereby affirm that I have read the above and fully understand and accept the conditions within.

_____

Client Name

_____

Client Signature

_____

Therapist Name

_____

Therapist Signature

_____

Date