CLIENT INFORMATION

Name: _____DOB:_____Gender:_____

Address:_____

Phone:_____Cell:_____

Email:_____Referred:_____

In case of emergency:_____Phone: _____

GENERAL & MEDICAL INFORMATION:

Have you ever experienced any Personal Awareness, Craniosacral &/or Movement sessions before? ____ If yes, how recently?
_____

Please circle **Y for Yes** or **N for No** for any of the following conditions or symptoms, which apply to you now or in the past:

Y or **N** High Blood Pressure
Y or **N** Blood Clots
Y or **N** Heart Attack/Stroke
Y or **N** Low Blood Pressure
Y or **N** Varicose Veins
Y or **N** Muscle Strain/Sprain
Y or **N** Numbness or Tingling
Y or **N** Epilepsy or seizures
Y or **N** Sharp or stabbing pain

Y or **N** Low Back Pain
Y or **N** Arthritis
Y or **N** Hypo/Hyperglycemia
Y or **N** Varicose Veins
Y or **N** Osteoporosis
Y or **N** Stress and/or Anxiety
Y or **N** Bruise easily
Y or **N** Diabetes
Y or **N** Headaches

Y or **N** Joint swelling
Y or **N** Pregnant
Y or **N** Contagious Conditions
Y or **N** Surgeries
Y or **N** Allergies
Y or **N** Cardiac problems
Y or **N** Circulatory problems
Y or **N** Tension or soreness

Please explain any of the above or other conditions/symptoms you have experienced:

_____
_____
_____
_____
_____
_____

If you have had any serious or chronic illness/operations/traumatic accident please explain:

_____
_____
_____
_____
_____

Do you have any history of surgeries ? Including dental. Please explain:

Is there a history of depression and/or anxiety?

Have you been hospitalized for mental health issues ? Please explain with current treatments:

Are you taking any medications? **Y or N** Please list below:

If a Woman, Your Child Bearing History. If a Man, do you have children and history:

Positive Impact History: Note people and things that either currently or in the past have supported and affirmed you in your life:

CLIENT CONSENT AND WAIVER FORM

Please initial each statement then sign and date below:

_____ I understand that Body of Wonder personal or group sessions, Craniosacral &/or Awareness based movement work with the BodyMind's natural & innate healing wisdom and Health resources for an improvement in sense of wellbeing, integration, energy flow and quality of life.

_____ I understand that I am totally in charge of my experience and that should anything feel inappropriate, I will say so. The purposes of the session is for me to access my own Innate and inner healing wisdom and Health resources and achieve a new balance, consciousness and optimal functioning in life.

_____ I understand that the practitioner does not diagnose illness, disease, or any other physical or mental disorder. The practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations. It has been made very clear that Body of Wonder personal or group sessions, Craniosacral &/or Awareness based movement sessions are not substitutes for medical examination or diagnosis and that it is recommended that I see a medical practitioner for any physical ailment that I may have.

_____ I understand that services offered today, and in the future are not a substitute for medical care and that any information provided by the therapist is for educational purposes **only**, and is **not** diagnostically prescriptive in nature.

_____ I have stated all of my known medical conditions on the Client Information Form, I have consulted a medical doctor or licensed medical health care practitioner regarding any checked or described conditions.

_____ I realize it is solely my responsibility to keep the practitioner updated on any changes in my physical health and I understand that the practitioner, shall not be liable should I fail to do so.

_____ I understand that all Body of Wonder personal or group sessions, Craniosacral &/or awareness based movement offered are strictly non-sexual. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

_____ By signing this release I hereby waive and release the practitioner/facilitator, of any and all liability, past, present, and future, relating to Body of Wonder personal or group sessions, Craniosacral &/or Awareness based movement. In addition, I agree to indemnify and hold them harmless from and against any and all claims, demands, fines, suits, actions, orders, or damages of any kind which may arise or result out of or from my utilization of services.

I have received the policy statement, and have read and agree to the policies therein:

Client Name: _____Name Parent/Guardian_____

Client Signature: _____Date: _____

Consent to treatment of a minor: By my signature below, I hereby authorize Prue Jeffries aka Body of Wonder
To administer Personal Awareness and Balancing Sessions to my child or dependent as they deem necessary.

Signature of Parent or Guardian_____ Date:_____