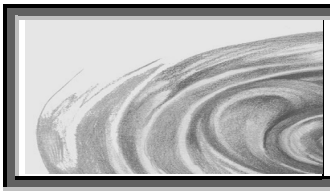

BodySoulHealing Verena Giebels, LMT, CCSP, MEd

Therapeutic Massage, Cranio-Sacral Therapy & Family Constellations

Phone: 360.421.6296 www.bodysoulhealing.abmp.com

1330 S 2nd St, St 103, Mt Vernon WA, 98273

Client Information

Name	Date of birth	Phone
Address	City ZIP	Email
Emergency contact	Relationship	Phone
Occupation	Physician	Health Insurance Carrier

Please take a moment to carefully read the following information and sign where indicated. Thank you.

Please write down any medications you are currently taking _____

Are you wearing contact lenses? O Yes O No Dentures? O Yes O No Have you experienced bodywork before? O Yes O No

What do you hope to gain from massage or cranio sacral therapy? _____

current	past		current	past	
O	O	Aids/HIV	O	O	Dental Braces, from _____ to _____
O	O	Allergies(list):_____	O	O	High Blood Pressure, under control Yes O No O
O	O	Arthritis	O	O	Infectious Diseases
O	O	Asthma	O	O	Multiple Sclerosis
O	O	Back Pain	O	O	Numbness, Tingling
O	O	Broken Bones (list): _____	O	O	Osteoporosis (location):_____
O	O	Cancer/Lymph Node Removal/Radiation	O	O	Pain/Shooting Pain
O	O	Cardiac or Circulation Problems	O	O	Phlebitis/Thrombosis
O	O	Chronic Fatigue	O	O	Pregnancy
O	O	Depression	O	O	Scolioses
O	O	Diabetes	O	O	Sleep Disturbances
O	O	Digestive Problems	O	O	Strains/Sprains
O	O	Disc Problems	O	O	Stroke
O	O	Epilepsy/Seizures	O	O	Swollen feet/joints/legs/ankles
O	O	Fever	O	O	Tendonitis
O	O	Fibromyalgia	O	O	TMJ Disorder/Issues
O	O	Headaches/Migraines (please circle)	O	O	Varicose Veins
O	O	Hepatitis A B C (please circle)	O	O	Whiplash

Please list any surgeries, injuries, accidents, chronic viral infection, trauma etc you have had and other health conditions not listed above:

_____

_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. I further understand that massage services are intended to be a health aid and in no ways take the place of a doctor's care. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. If I need to cancel my appointment, I give 24 hour notice unless an emergency arises. In case I forget to cancel on time, I agree to be charged the full amount of my appointment.

_____

Signature of client Date

Consent to Treatment of Minor: By my signature below, I hereby authorize **Verena Giebels, LMT, CCSP** to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

_____

Signature of parent/guardian Date