

Client Information

NAME _____ PROFESSION _____

ADDRESS _____ DATE OF BIRTH _____

CITY _____ PROVINCE _____ POSTAL CODE _____

TELEPHONE _____ EMAIL _____

HOW DID YOU FIND US? _____ Join Mailing List? [y] [n]

What would you like to include? [circle any]

Swedish / Deep Tissue / Thai / Reflexology / Lomi Lomi / Stretching / Head and Face / Energy Healing / Reiki / Reconnective Healing / Craniosacral Therapy / SomatoEmotional Release / Tok Sen / Singing bowls / Tuning forks / Gongs

What are you seeking? [circle any]

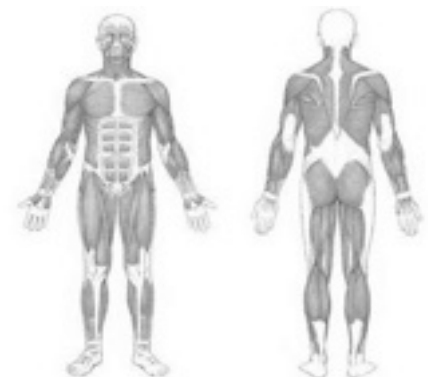
Stress Relief / Pain Relief / Energy Boost / Relaxation / Tranquility / Quietude / Integration / Centering / Nuturement / Upliftment / Clearing / Emotional Healing / Alignment / Getting through difficulties / Personal Development / Manifestation / Spiritual Healing / Shifting Consciousness

Anything else or any other intentions? _____

Please circle any of the following conditions that apply to you:

- | | |
|----------------------|----------------------|
| Allergies | HIV/AIDS |
| Arthritis | Joint Pain |
| Artificial Joints | Kidney Disease |
| Back Pain | Low Blood Pressure |
| Cancer | Multiple Sclerosis |
| Carpal Tunnel | Muscle Tension |
| Circulatory Disorder | Neck Pain |
| Diabetes | Pregnant |
| Digestive Disorder | Respiratory Disorder |
| Epilepsy | Skin Disorder |
| Headaches | Steel Pins |
| Heart Condition | TMJ |
| Heat Sensitivity | Varicose Veins |
| High Blood Pressure | Others _____ |

Please mark areas of concern and areas to avoid if any:



Pressure preference:
soft medium deep

Please explain your condition and if under other health care providers:

Please note any current medications: _____

Disclaimer

I, _____ (print name) understand that Constance Au does not diagnose illness, disease, or mental disorder. Nor does she prescribe medical treatment or pharmaceuticals. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. It has been made clear that this session is not a substitute for medical examination or diagnosis and that it is recommended that I see a M.D., physician, chiropractor or other qualified medical specialist for any physical or mental ailment. With this in mind I agree that this session and Constance Au cannot be held liable for any problems that might arise that I think could be attributed to the session. I have stated all of my known medical conditions and will keep Constance Au updated on my physical, mental, and emotional health. I release Constance Au from any and all claims of malpractice, non-disclosure, or lack of informed consent.

I understand that any sexual advances, suggestions, conversations and behaviour are absolutely not tolerated during sessions. If this kind or other disrespectful behaviour happens, my session may be terminated at anytime and will be charged for the full amount. If I arrive late to the appointment, I would only receive the remaining of the scheduled time and be charged for the full amount.

Client Signature _____ Date _____