mettafor
TRANSFORM WITHIN

87 Alma St South, Guelph, ON, N1H 5W8
519.760.1372 sandi@**mettafor.com**

Client Consent *I acknowledge and agree that:*

- Sandi Beaupre will not diagnose conditions, prescribe substances, perform medical treatment, or interfere with treatment of a licensed medical professional. Services offered are not a substitute for medical care.
- Techniques & modalities aim to balance the flow of energy, reduce stress on body/mind and assist optimal functioning by stimulating my body's self-healing mechanisms, which allow my body to heal itself.
- Sandi is not liable for personal discomfort of any nature that can arise from or in the process of whole-body healing.
- I accept responsibility for myself at all times, will communicate openly and will advocate for myself during my session(s).
- My health history is accurate, used to aid safe treatment and is confidential. I will notify if anything changes.
- I will pay the advertised fee at the time service is rendered. If I am running late, I will call immediately and understand that my time may be shortened as a result. I understand that 24hrs notice is required to cancel or reschedule an appointment. For a late cancellation or missed appointment, I will be responsible for 50% of my service fee to be paid within 24hrs.

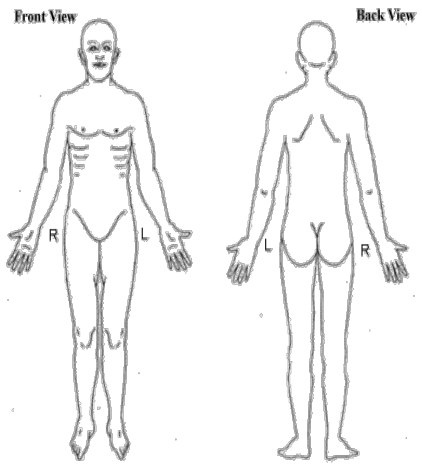
Please silence your cell phone for the duration of the session

Personal Information (please print clearly)		
Full Name	Email	City of Residence
Best Phone # ( )	Date of Birth	Occupation
Emergency Contact	Phone # ( )	May we add you to our email list to inform of special offers and updates? □Yes □No
How did you hear about mettafor? □Internet □Gift Certificate □Friend _____ □Other_____		

General Health History		
Are you using other therapies for your health at this time?	□Yes □No	
Do you have movement restrictions/challenges? (i.e twisting)	□Yes □No	
Are you taking medications (if so, for what reason)?	□Yes □No	
Do you have allergies? (environment, food, oils, perfumes etc)	□Yes □No	
Do you have inflammation or recent injury to any area?	□Yes □No	
Do you wear contact lenses?	□Yes □No	
Do you have difficulty in any the following positions? (seated on floor/chair, lying face down/on back/on side)	□Yes □No	
Women: Are you currently pregnant? # of weeks	□Yes □No	

Please CIRCLE below all that apply

- Burnout, Panic Attacks, High Stress, Anxiety, Depression, Fear/Phobias, Addiction, Sleep Disturbances
- Skin Condition/infection, Cuts/Wounds, Burns, Cold Sores, Immune Disorder, Hormone Imbalance, Hysterectomy
- Headaches, Migraines, Joint Pain/Stiffness, Arthritic Condition, Epilepsy, Seizures, Diabetes, Cancer, Hepatitis
- High/Low Blood Pressure, GI condition, Respiratory problem, Urinary Condition, Kidney Condition, Cardiac Condition
- Cosmetic Surgery, Pacemaker, Metal Implants/Replacements



Client Signature: ***Date:***