mettafor
TRANSFORM WITHIN

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

Client Consent

I, the undersigned, acknowledge and agree that:

- ○ Sandi Beaupre is not qualified to diagnose physical or mental conditions. Services offered aim to reduce stress, relieve pain, re-balance energy, and improve mobility and function by reeducating self-healing capacities.
- ○ All explorations are undertaken voluntarily. I accept responsibility for myself at all times, and will communicate openly if I am uncomfortable.
- ○ My health history is accurate, used to aid safe treatment and is confidential. I will notify if anything changes.
- ○ I will pay fees at the time service is rendered. I understand 24hrs notice is required to cancel or reschedule an appointment; otherwise I am responsible for 50% of my service fee to be paid within 24hrs.

Personal Information

FULL NAME: ______________________________ AGE: ____________

EMAIL: ______________________________ PHONE: ____________

ADDRESS: ______________________________

OCCUPATION: ______________________________ HANDEDNESS: ○ Left ○ Right

EMERGENCY CONTACT NAME ______________________________ PHONE ____________

How did you hear about Sandi/Mettafor? ______________________________

What daily movement habits do you have? *(e.g. lifting, desk work)*

____

Any allergies? (*e.g. environmental, pet, oils, perfumes, etc.*): ______________________________

May we add you to our email list to inform you of special offers, classes and updates? ○ Yes ○ No

General Health History

1. List any accidents, injuries, major illnesses or surgeries you've experienced throughout your life *(include approximate year and age, e.g. Broke left ankle, 2003, age 21)*:

2. Where do you feel RESTRICTED or LIMITED in your movements?

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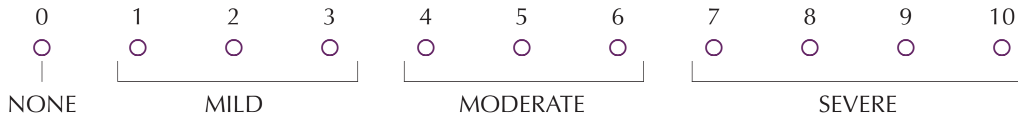
3. Please check all that apply to you:

○ Anxiety	○ Cuts/Wounds	○ Headaches/Migraines	○ Respiratory Condition
○ Arthritis (Osteo, Rheumatoid)	○ Depression	○ Hormone Imbalance	○ Sciatica
○ Balance Issues	○ Diabetes	○ Hysterectomy	○ Scoliosis
○ Blood Pressure (High/Low)	○ Disc Herniation	○ Metal Implants	○ Sleep Disturbances
○ C Section Birth	○ Eczema or Psoriasis	○ Multiple Sclerosis (MS)	○ TMJ
○ Cancer	○ Epilepsy or Seizures	○ Osteoporosis	○ Vertigo
○ Cardiac Condition	○ Gastrointestinal Condition	○ Panic Attacks	○ ________________
○ Cold Sores		○ Parkinson's	○ ________________

4. Are you currently receiving treatment from a health care provider? ○ Yes ○ No

5. Specify the location and nature (*achy, numb, piercing, etc.*) of your current muscle and joint pain/tension:

Check your current level of pain or discomfort:



6. On a scale from 0-10, check what level of stress you consider your current lifestyle?

Reason(s) for stress: ____________________

7. Do you have difficultly in any of the following positions: seated, lying face down, flat on back, side lying? ○ Yes ○ No

If yes, please explain:

8. Are you currently taking medication(s)? If so, for what reason(s)?

9. What would you like to get out of these session(s)? Targets/Aspirations?

10. Are you currently pregnant? ○ Yes ○ No # of weeks ______ Is this your first pregnancy? ○ Yes ○ No

CLIENT SIGNATURE ____________________ DATE ____________