

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?

3. Please check all that apply to you:

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

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 difficulty 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 _____