ILLUMINATE

"We are all lit from within."

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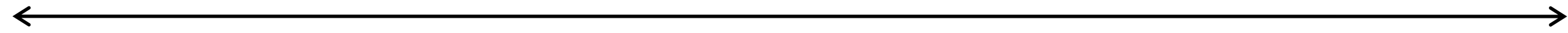

CLIENT INFORMATION

Name____ Date_______________

Address____

City, State, Zip ____

Phone: Work ____________________ Home ______________________ Cell______________

Occupation __________________________Email ___________________________________

Date of Birth ___________________________ Referred by___________________________
(Parental consent required if under 18)

Reason for your visit____

Please list any recent or past injuries or medical treatments___________________________

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Current Medications ____
(ALL INFORMATION WILL BE KEPT CONFIDENTIAL)

Do any of the following apply to you? (Please check)

- ☐ Allergies
- ☐ Acute pain
- ☐ Addictive tendencies
- ☐ Arthritis
- ☐ Back problems
- ☐ Bulimia
- ☐ Cancer
- ☐ Contagious diseases
- ☐ Chronic pain
- ☐ Depression
- ☐ Diabetes
- ☐ Dislocations/fractures
- ☐ Edema
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Headaches
- ☐ Heart ailments
- ☐ Hepatitis
- ☐ Hernia
- ☐ High blood pressure
- ☐ Hyperthyroid
- ☐ Hypoglycemia (Low blood sugar)
- ☐ Hypothyroid
- ☐ Infectious condition
- ☐ Infertility
- ☐ Loss of apetite
- ☐ Low blood pressure
- ☐ Migraines
- ☐ Muscle cramping
- ☐ Numbness/tingling
- ☐ Neck problems
- ☐ On medication
- ☐ Osteoporosis
- ☐ Pregnancy
- ☐ Psychological disorder
- ☐ Recent injury
- ☐ Skin disorder
- ☐ Sport injury
- ☐ Stomach/digestive problems
- ☐ TMJ syndrome
- ☐ Ulcer
- ☐ Other

Anything else I should be aware of? ____

Are you currently under the care of a health professional? ____No ________Yes.

If so, why?____

____

Please provide an emergency contact:

Name and relationship: ____

Phone: Work __________________________Cell __________________________Home ________________________

This request for information does not imply, in any way, the practice of medicine or diagnosis of a client's condition. We reserve the right to restrict service to, or decline acceptance of the client.

Please read the following and then sign and date below.

I acknowledge that I have read and understand all of the questions on this form and that this information is made available to all Illuminate personnel in order to provide me with the assistance that I have requested. The information is correct to the best of my knowledge and will be kept confidential and only released with my approval or in compliance with legal action requirements.

This is to certify that I am requesting services of my own initiative and I realize that ailments will not be diagnosed nor will treatments be prescribed. I release Lois Weik, Illuminate, Losef Technologies West, Inc., and its staff from any liability for claims resulting from the use of its services. I understand that certain conditions (fever, surgery, inflammation, high-risk pregnancy, infectious diseases, etc.) are contraindications to massage and craniosacral therapy and I will keep Illuminate personnel updated with regard to my health, and will get medical clearance prior to coming in.

I understand that payment is due at the time of treatment unless other arrangements have been made in advance. I agree to give 24 hours notice of cancellation for any appointment. If less than 24 hours notice is given, I agree to pay for my appointment. I understand that if I am late for an appointment, I may not be able to receive a full session but I remain responsible for the full charge. Cases of extreme emergency are considered exceptions.

I understand that massage or craniosacral therapy is not a substitute for medical treatment.

Signature: ____ Date: _________________

Please use the space below for any additional information