

Giving Nature™ Center for Holistic Health & Wellness

Holistic Services Client Information

Today's Date: _____

Name: _____ Home Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Business Phone: (____) _____ Fax: (____) _____

City: _____ State: _____ Zip: _____ Email Address: _____

Birthdate: _____ Gender: _____ Number of Children: ____ Ages: _____

Occupation: _____ Referred by: _____

Contact in emergencies: _____ Phone: _____

How would you describe your current state of health? _____

Please list any medications, herbs, or supplements you are currently taking, whether prescription or non-prescription: _____

Please list any history of serious injuries, illnesses or hospitalizations: _____

Giving Nature™ Center for Holistic Health & Wellness

Holistic Services Informed Consent

I understand that Giving Nature Center for Holistic Health & Wellness offers treatments using Craniosacral Therapy, Jin Shin Jyutsu™, Polarity, Connective Tissue Therapy, Breathwork and Movement Therapy, all of which are intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

I understand that holistic therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my primary healthcare provider for any condition I may have. I am aware that the holistic therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of holistic therapy. I have informed the therapist of all my known physical and medical conditions, and I will keep the holistic therapist updated of any changes. I will notify the holistic therapist should I become pregnant or if I am trying to become pregnant.

I understand the practitioner and administrative staff may review my medical records and reports, but all of my records will be kept confidential and will not be released without my written consent.

I have read and understand this consent to treatment. I have been informed about the risks and benefits of holistic therapy procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Client Signature

Date

Please Note:

This office has a 24 hour cancellation policy. We ask that you notify us well in advance if you need to cancel or change your appointment. Payment in full will be due for all sessions cancelled with less than 24 hours. Monday appointments must be cancelled by Friday.

By signing here I agree to pay for any missed appointment when it is not cancelled with a minimum of 24 business hours notice.

Signed

Printed Name

Date: _____