Michelle Wald, LMT certified Aston-Patterning® practitioner

2304 Hancock Dr Suite 7B Austin TX 78759

Name _____**Male** _____**Female** _____**DOB**_____

Address_____**City/State**_____

Home Phone _____**Cell Phone**_____

Email_____**Right or Left handed (please circle)**

Who Referred You? _____

Occupation_____

Physical activities/Exercise_____

Hobbies/Interests_____

Reason for seeking Aston-Patterning®_____

Goals for Treatment-What do you hope to achieve with these sessions?

_____

Previous bodywork experience_____

If you are currently experiencing any relevant or chronic conditions please discuss these with me and *circle* the appropriate item below or add any conditions not listed.

Pregnancy	Heart Conditions	Diabetes	Pulled Muscles
Blood Clots/Varicose Veins	Digestive Problems	Headaches/Migraines	Fibromyalgia
Dislocations	Hepatitis	Nausea	Back Injuries
High Blood Pressure	Hypo/Hyperglycemia	Fainting Spells	Neck Injuries
Skin problems	Respiratory Conditions	Depression	Fractures
Cancer	HIV	Seizures	Recent Surgeries

Please list any and give the years of past surgeries, broken bones, major accidents or serious illnesses.

_____

Are you currently receiving any forms of professional Healthcare? _____

List any Medications or vitamins your are currently taking, (prescribed or over the counter)

_____

List any Allergies (Drug-Food-Environmental) _____

Disclosure:

1.You will receive some Newsletters and Blog posts which relate to my business- check here if you wish to opt out_____

2. During your session you may be getting up from the table so you will be draped and wearing gym attire.

3. If, at any time during your session you feel uncomfortable for any reason, please advise your therapist.

You may, at any time, ask the therapist to stop the massage and end the session.

4. No breast Massage will be performed on clients without prior consent and only if indicated by a medical condition.

5. Cancellation Policy- if you cancel your appointment with less than 24 hours notice,

***You will be responsible for payment of your session*.**

I have read, understood and agree to the above statements and the recommended treatment plan as stated below.

_____

Client Signature *Date*

_____

Therapist Signature *Date*

Recommended Treatment Plan (to be completed by therapist)