Physical Therapy & Bodywork

CLPT
CONSCIOUS LIVING PHYSICAL THERAPY

CLIENT INFORMATION

Name: Date of birth:

Address:

Telephone: Mobile Telephone: E-mail:

In case of emergency: Telephone:

Occupation: Male: ☐ Female: ☐

SELECT SERVICE

PHYSICAL THERAPY ☐ STRUCTURAL INTEGRATION ☐ THAI YOGA THERAPY ☐
CORRECTIVE BODYWORK THERAPY ☐ ENERGY HEALING THERAPY ☐ CRANIOSACRAL THERAPY ☐

- **Please take a moment to carefully read the following information and sign where indicated.**
- **If you have a specific medical condition or specific symptoms, manual therapy may be contraindicated.**
- **A referral from your primary care provider may be required prior to service being provided.**

Have you ever experienced a professional massage or bodywork session? Yes: ☐ No: ☐
How recently?

What are your PT / Structural Bodywork goals?

If you answer "yes" to any of the following questions, please explain as clearly as possible.

Do you frequently suffer from stress? Yes: ☐ No: ☐

Do you have diabetes? Yes: ☐ No: ☐

Do you experience frequent headaches? Yes: ☐ No: ☐

Are you pregnant or trying to get pregnant? Yes: ☐ No: ☐

Do you suffer from any severe menstrual problems? Yes: ☐ No: ☐

Are you using an IUD? Yes: ☐ No: ☐

Do you suffer from arthritis? Yes: ☐ No: ☐

Are you wearing contact lenses? Yes: ☐ No: ☐

Are you wearing dentures? Yes: ☐ No: ☐

Do you have high blood pressure? Yes: ☐ No: ☐

Are you taking high blood pressure medication? Yes: ☐ No: ☐

Do you suffer from epilepsy or seizures? Yes: ☐ No: ☐

Do you suffer from joint swelling? Yes: ☐ No: ☐

Do you have varicose veins? Yes: ☐ No: ☐

Do you have any contagious diseases? Yes: ☐ No: ☐

Do you have osteoporosis? Yes: ☐ No: ☐

Do you have allergies? Yes: ☐ No: ☐

Do you bruise easily? Yes: ☐ No: ☐

Any broken bones in the past two years? Yes: ☐ No: ☐

Any injuries in the past two years? Yes: ☐ No: ☐

Do you have tension or soreness in a specific area? Yes: ☐ No: ☐

Do you have cardiac or circulatory problems? Yes: ☐ No: ☐

Do you have a pacemaker or shunts? Yes: ☐ No: ☐

Do you suffer from back pain? Yes: ☐ No: ☐

Do you have numbness or stabbing pains? Yes: ☐ No: ☐

Are you sensitive to touch or pressure in any area? Yes: ☐ No: ☐

Have you ever had surgery? Yes: ☐ No: ☐

Do you suffer from back pain? Yes: ☐ No: ☐

Do you have a pacemaker or shunts? Yes: ☐ No: ☐

Do you have any history of Embolism, Phlebitis or DVT? Yes: ☐ No: ☐

Do you suffer from any Inflammatory Bowel Conditions? Yes: ☐ No: ☐

Do you have colostomy/s? Yes: ☐ No: ☐

Do you have any Neurological conditions? Yes: ☐ No: ☐

Do you suffer from Multiple Sclerosis? Yes: ☐ No: ☐

Do you suffer from Cerebral Palsy? Yes: ☐ No: ☐

Do you have any Psychotic Conditions? Yes: ☐ No: ☐

Do you have any Degenerative Spinal Conditions? Yes: ☐ No: ☐

Do you have any history of Tumors? Yes: ☐ No: ☐

Do you have osteoporosis? Yes: ☐ No: ☐

Have you had Cortisone Injections? Yes: ☐ No: ☐

If so when?

Do you have any history of strokes or Aneurysm? Yes: ☐ No: ☐

Are you taking any medication? Yes: ☐ No: ☐

Do you have cardiac or circulatory problems? Yes: ☐ No: ☐

Are you taking any medication? Yes: ☐ No: ☐

Do you have Significant Atherosclerosis or Arteriosclerosis? Yes: ☐ No: ☐

Other medical conditions? Yes: ☐ No: ☐

Please specify:

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure, intensity and/or strokes may be adjusted to my level of comfort. I further understand that Physical Therapy and or structural bodywork therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that Physical Therapists or other manual therapy practitioners are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because manual therapy or structural bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Client signature: Date:

Consent to Treatment of Minor: By my signature below, I hereby authorize Conscious Living Physical Therapy to administer manual therapy, structural bodywork, or somatic therapy techniques to my child or dependent as they deem appropriate.

Signature of Parent or Guardian: Date:

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Informed Consent and Waiver

It is important that you get to know and understand the salient points of physical therapy. In addition, just like any other medical treatment, there are benefits and risks involved in this treatment. We shall explain it also here in this informed consent and you can also ask if you have further questions or you need clarification. We will answer and explain them to you. Before a procedure shall be done, we will make sure to explain them to you first. Please note that you have the right to decline any part of the treatment before or during treatment. You have the right to ask your physical therapist about the treatment plan and discuss the potential risks and benefits of the treatment.

- I understand that Physical Therapists, Manual Therapists, Body workers and holistic practitioners are not medical doctors and do not diagnose disease, or any physical or mental disorder. I acknowledge that manual therapy and alternative holistic therapies are not substitutes for medical treatment, and that David Kalen and "Conscious Living Physical Therapy", the company, recommend I see a primary healthcare provider for that service. I understand that it is my responsibility to communicate with my therapist if I have concerns or questions about my session. I do not have any injuries or conditions that would prevent me from receiving a manual therapy or bodywork, nor have I been told by a health care provider that I should not receive manual therapy or alternative therapies.

- I understand that Physical Therapy and Body work services are a therapeutic health aid and are non - sexual. I understand my practitioner reserves the right to end a therapy session in the case of sexual innuendo or advances from the client. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the therapy, and I will be Liable for the full payment of the scheduled session.

- Any information exchanged during a session is confidential and is only used to provide me with the best health care services available. I understand that a PT / manual therapist will ask me questions about my health and physical condition and that I am obligated to answer truthfully and honestly about my health history in full detail.

- I understand that my feedback is essential in my treatment, and that if I experience any unusual discomfort and/or pain during my therapy session, it is my responsibility to inform the therapist in order to enable the therapist to adjust the pressure or technique being used.

- The therapist reserves the right to decline, discontinue, or restrict services based on any provided information that may indicate that Physical Therapy or Bodywork Therapy would put my health or the therapist's health at risk.

- I acknowledge that I am responsible to be on time for my appointments and that the therapist is not under any obligation to Extend my therapy session. I also agree that I am responsible to pay for the full time I have booked with the therapist if I am late. I understand that my appointment time is reserved for me only. If I miss an appointment or am unable to give twenty four (24) Hours' notice when I need to change or cancel my appointment, I agree to pay the company in full for the booked appointment time. I further understand that I will be additionally charged $30.00 for any returned checks.

- I understand that the practitioner does not prescribe medical treatment of pharmaceuticals.

- I understand that service offered today, and in the future, are not a substitute for medical care and that any information provided to me by the therapist is purely for educational purposes and is not diagnostically prescriptive in nature.

- I understand that it is solely my responsibility to keep the therapist updated on any changes in my physical health and I further understand that the company and the therapist shall not be liable for any purpose and for any reason whatsoever, should I fail to do the needful as per this paragraph.

- I have stated all of my known medical conditions on the Client Intake form. I have consulted a medical doctor or licensed medical health care practitioner regarding any checked or described conditions.

- I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Conscious Living Physical Therapy and the equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to, bodily injury, disease, soreness, strains, numbness, tingling, muscle tears, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Conscious Living Physical Therapy, or by any other person; (d) I know that I have the right to choose what treatment I do or do not receive, in addition to withdrawing from treatment at any time; (e) I recognize that my participation in the activity covered hereby is conditioned upon my signing and returning this waiver and release.

- I consent to and authorize Conscious Living Physical Therapy (including students in training) to administer physical therapy treatment under the direction and supervision of the physical therapist. I understand and I am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have, as well as medications I am taking.

- There are no guaranteed expectations when one undergoes physical therapy treatment. This depends on the situation. But when one undergoes a physical therapy program, it is intended that one will be able to return to his or her prior level of functioning or develop a method to continue what was possible to be performed before the injury that is no longer possible after being permanently injured. When going through the program, it is important that the patient is truthful with what he or she thinks or feels. Proper communication is important for the progress of the patient.

- As physical therapy intends to resolve the problem that the person is experiencing due to illness or injury, there are some risks that may arise during the course of the treatment such as pain and discomfort during the process of therapy. Stretching and twisting may cause some swelling and soreness of stiff muscles. This is normal. There are therapies that may use hot or cold compresses in order to relieve the pain during therapy. Your physician may prescribe drugs in order to help you with the pain and swelling while going through the process of physical therapy. Please take note that some can experience pain and discomfort that may reduce one's motivation to continue due to pain or lack of manifesting results. It is important that the person continues with the therapy if it is too early to conclude the results. It would be best to discuss these matters with your physical therapist.

- Under the Healthcare Insurance Portability and Accountability Act of 1996 (“HIPPA”), we are required that all medical information of every individual be kept securely and shall not be disclosed to anyone. This allows the patient to have the right on how his or her information and how it shall be used. The records we acquire from you shall be used for managing health care by health care providers and will be used for reference for payment or reimbursement for services such as billing or collection. We may also use your information for the assessment and improvement of our activities and business operations.

- I have reviewed this form in its entirety and I have discussed all my concerns regarding my treatment with my therapist

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CLIENT:

By signing this "Informed Consent and Wavier", I consent to receive treatment at Conscious Living Physical Therapy and hereby agree to all policies of CLPT, and waive and release CLPT and its entire staff, Physical Therapists, Massage therapists, manual therapists and Bodywork practitioners from any and all past, present, and future liability, loss, cost, claim, or damage whatsoever which may be imposed upon the Company relating to Physical Therapy and Bodywork; including but not limited to reflexology, acupressure, polarity therapy, energy therapy, Reiki, nutritional therapies, all forms of kinesiology, aromatherapy, craniosacral therapy, myofascial release therapy, trigger point therapy, stretching therapy, strength and condition training, among others. I further undertake to indemnify and hold Conscious Living Physical Therapy from any incident(s) arising from my use of their services. I specifically understand that I am releasing, discharging, and waiving any claims that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Conscious Living Physical Therapy. I understand that I may show this INFORMED CONSENT and WAIVER & RELEASE OF LIABILITY to, and consult with, my own independent legal counsel before signing.

Client Signature: Date:

Printed Name: Telephone:

Address:

PARENT/GUARDIAN - WAVIER FOR MINORS:

If the client is less than 18 years old, the Client's parent and natural guardian hereby represents that he/she is, in fact, Acting in that capacity, has consented to his/her child or ward's availing of the services of Conscious Living Physical Therapy, and has agreed individually and on behalf of the child or ward, to the terms of this "Informed Consent and Wavier". The undersigned parent or guardian further agrees to save and hold harmless and indemnify Conscious Living Physical Therapy and its entire staff from all liability, loss, cost, claim, or damage whatsoever which may be imposed upon Conscious Living Physical Therapy and David Kalen, relating to Physical Therapy and body work; including but not limited to reflexology, acupressure, polarity therapy, energy therapy, Reiki, nutritional therapies, all forms of kinesiology, aromatherapy, craniosacral therapy, myofascial release therapy, trigger point therapy, stretching therapy, strength and condition training, among others, on behalf of the Client and all of the Client's parents or legal guardians.

Parent / Guardian Signature: Date:

Printed Name: Telephone:

Address: