Structural Energetic Therapy

INFORMED CONSENT

I _____understand that Structural Energetic Therapy (hereafter referred to as SET) is a therapeutic and rehabilitative therapy for musculoskeletal problems.

- I understand that the SET Practitioner is highly trained in advanced SET Techniques and that SET treatment is unique and is not like other massage treatments I may have had.

- I understand that, due to its structural nature, it will be necessary for my structural alignment to be observed while standing with most of my body visible to the examiner.

- I understand that the SET Practitioner will ask me to participate in the evaluation process by using structural observation, kinesiology and an interview that may include questions about health history, current medications and life style.

- **I agree to keep the SET Practitioner updated on any changes in the status of my health.**

- **I agree to inform the SET Practitioner of <u>any and all medication changes</u> that occur throughout the duration of my SET treatments.**

- I understand that the optimum number of SET sessions will be determined by the SET Practitioner in order to achieve the rehabilitation goals based on my condition.

- I understand that the SET Practitioner may at any point in the treatment, using his/her professional judgment, decide that I have reached my limit for that particular treatment.

- I understand that it is my responsibility to communicate to the SET Practitioner if I feel I have reached the end of my tolerance for SET Therapy within any given session.

- I give my permission to the SET Practitioner to move clothing aside when necessary in order to work on soft tissue that would usually be covered by a bathing suit (genitals will not be exposed and modesty will be respected). When the therapist explains the reason for working specific soft tissue, I agree to communicate to the therapist if it is NOT okay for the area to be either touched or exposed for treatment (such as hips, gluteals).

- I understand that payment is due in full upon completion of the session unless other arrangements have been made.

- **I understand that if I do not cancel a scheduled appointment at least 24 hours in advance I am responsible for paying the full fee for that time.**

Client Signature:_____Date:_____

Signature of parent/guardian if appropriate: _____

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CLIENT HISTORY FORM

Name:_____Date:_____

Address:_____Email:_____

City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Height:_____Weight:_____Age:_____ # of Children:_____Occupation:_____

Emergency Contact: _____Relationship:_____Phone #_____

Who referred you to this office?_____

Method of payment: (circle one)____Cash_____Check_____Credit Card *(MC, Visa)*_____

Who is responsible for payment (if not you)?_____

* *

Are you taking a blood thinner? N Y – name:_____
(PLEASE NOTE: I cannot do bodywork on you if you are taking prescription blood thinners – aspirin is not a problem! Blood thinner medication is <u>not</u> an issue for breathwork)

Describe major complaint: _____

_____

<u>When</u> and <u>how</u> did your condition develop?_____

_____

What makes your condition worse? _____

_____

List diagnosis (if known) and current treatment: _____

_____*(If available, please bring current reports: MRI, X-rays, Medical)*

Are you currently under doctor care? N Y – please explain:_____

_____

If auto accident, give date and description: _____

_____

Results from previous massage treatments: _____

_____

All surgeries & serious illnesses with approximate year:_____

_____

Dental work: Dentures? N Y – full___, partial___; Implants: N Y; Bridge: N Y – permanent____, removable____

Do you wear contact lenses? N Y Do you wear orthotics? N Y Facial surgeries? N Y _____

List ALL current medications: _____

_____

(over please)

Do you have any skin disorders or allergies (i.e. latex)? N Y – please explain:_____

_____

Do you regularly drink caffeine beverages (coffee, tea, sodas, etc.) N Y – frequency _____

Do you smoke? N Y – how much? _____

Are you pregnant? N Y

Are you participating in a regular fitness program? N Y – please describe:_____

_____

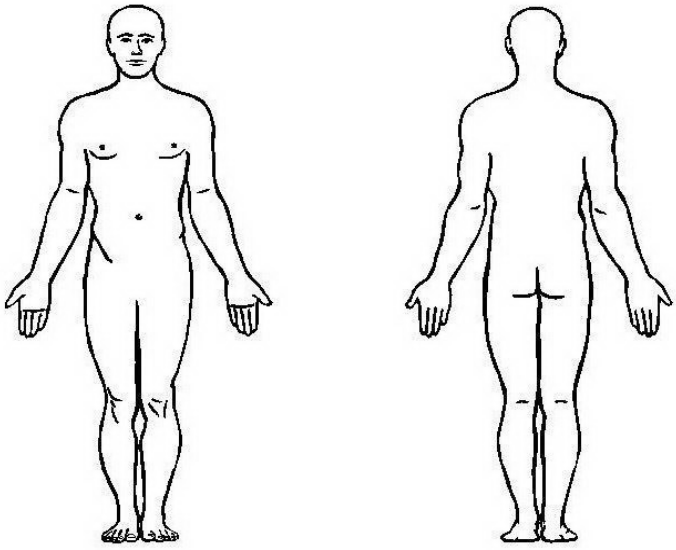
Do you have any other medical condition or physical limitation that I need to know before you receive this bodywork?

N Y – please explain:_____

Please circle any of the following that apply, present or past:

AIDS (or HIV related	Severe Irritability
Abdominal hernia	Severe Depression
Hiatal Hernia	Severe Menstrual Pain
Acid Reflux	PMS
Stomach Disorders	Fatigue
Constipation	Broken Bones
Diarrhea	Herniated Disc
Arthritis	Headaches
Bursitis	Sinusitis
Diabetes	TMJ
Cancer	Neck Pain
Shortness of Breath	Back Pain
Chest Pain	Sciatic Pain
Heart Conditions	Knee Pain
Low Blood Pressure	Feet Cold
High Blood Pressure	Foot Numbness
Varicose Veins	Foot Pain
Blood Clots	Shoulder Pain
Dizziness	Arm / Elbow Pain
Loss of balance	Carpal Tunnel
Fainting Spells	Hand Numbness
Ears Ring	Hands Cold
Edema	Scoliosis

Please shade areas of pain and discomfort



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I have listed ALL my known medical conditions, physical limitations and medications. **I will inform my therapist of any changes in my physical health or medications.** I understand that an RN or SET therapist does not diagnose illness, disease, or any other medical, physical or psychological disorder, nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any problems that I have.

I agree to pay for all services at the time they are rendered unless prior arrangements have been made.

<u>CANCELLATIONS and MISSED APPOINTMENTS:</u> We require 24 hr. notice for any schedule changes, or you will be responsible for the full session fee. We cannot do bodywork sessions if you are sick. If there is a question, please call.

I understand the information contained herein is privileged and confidential. I authorize the release of any information pertaining to my health to my attorney, insurance company, or referring physician / therapist.

Signature:_____Date:_____

If client is a minor, signature of Parent/Guardian: _____