

Patient Name: _____
 Date of Birth: ____/____/____
 Age: ____ Male Female
 Address: _____
 City: _____, MN Zip: _____
 Telephone: () ____ - ____
 Email address: _____

Occupation: _____
 Health Insurance Carrier: _____
 Referred by: _____
 Telephone: () ____ - ____
 In case of emergency: _____
 Telephone: () ____ - ____

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

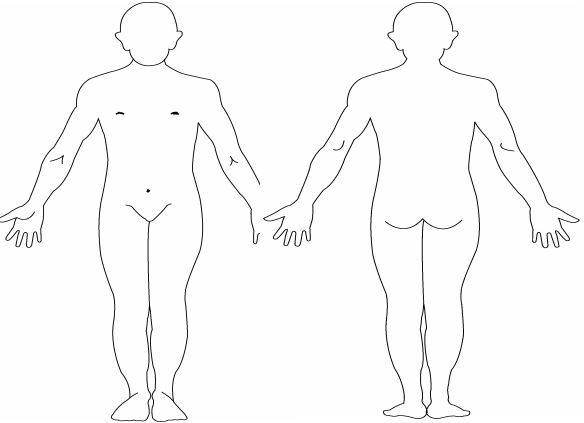
Yes No Have you ever experienced a professional massage or bodywork session? How recently? _____

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

- Yes No Do you frequently suffer from stress?
- Yes No Do you have diabetes?
- Yes No Do you experience frequent headaches?
- Yes No Are you pregnant?
- 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 If "yes" to previous question, are you medication for this?
- Yes No Do you suffer from epilepsy or seizueres?
- 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 Have you had any broken bones in the past two years
- Yes No Have you been in an accident or suffered any injuries in the past tow years?
- Yes No Do you have tension or soreness in a specific area?
Please specify: _____
- Yes No Do you have cardiac or circulatory problems?
- Yes No Do you suffer from back pain?
- Yes No Do you have numbness or stabbing pains anywhere?
- Yes No Are you very sensitive to touch or pressure in any area?
- Yes No Have you ever had surgery? Explain below.
- Yes No Do you have any other medical condition or are you Taking any medications I should know about?

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING
 Mark the areas on this body where you feel the described sensations.



Comments: _____

Client Signature: _____
Date: _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____, to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____
 Date: _____



Natural Elements Health Center

Patient Name: _____

Christine Schlenker, D.C.

Date: _____

900 Highway 23 W Suite 3 Milaca MN 56353

Tel. 320.983.2333 staff@naturalelementshealth.com

Client Bill of Rights for Massage

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, or 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 massage 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. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

We ask for a 24 hour notice if you are not able to make your appointment. If you fail to cancel in a timely matter and/or do not show up to your appointment you will incur a \$25.00 service fee.

(Please check the box indicating that you have read this policy).

Client Signature: _____ Date: _____

Ionizing Foot Cleanse Release Form

Before using the Foot Ion Cleanse or any similar device, you are advised to consult a physician. A person with any of the following conditions should not use the Ion Cleanse:

1. Anyone with a pacemaker or other battery operated electrical implant.
2. Anyone on heart medication.
3. Anyone on medication, the absence of which would mentally or physically incapacitate them. For example, psychotic episodes, seizures, etc.
4. Pregnant, possibly pregnant, or nursing.

The Foot Ion Cleanse is used to demonstrate the build up of toxic substances that lodge in the human body. Most people have a sense of well being after a cleanse. This cleanse is not diagnostic.

I hereby release the therapists of the Foot Ion Cleanse, Christine Schlenker, D.C. or Kristie Hendel; and the establishment of Natural Elements Health Center, Inc. from any responsibility or liability related to my participation with the Foot Ion Cleanse. I am responsible to notify the therapists of any change in health or medication status that could determine if I do or do not qualify to participate in the Foot Ion Cleanse.

Signature: _____

Date: ____/____/____