CLIENT INFORMATION		
Name:		Date of Birth:
Street Address:		Phone #:
City:	State:	Zip:
In an Emergency, contact:		SSN #:
Referred by:		Phone #:

General & Medical Information

Age:	Sex: Male Female

Yes No – Have you every 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 bruise easily?
Yes No – Do you have diabetes?	Yes No – Have you had any broken bones in the past two years?
Yes No – Do you experience frequent headaches?	Yes No – Have you been in an accident or suffered any injuries in the past two years?
Yes No – Are you pregnant?	Yes No – Do you have tension and soreness in specific areas?
Yes No – Do you suffer from arthritis?	Yes No – Do you have cardiac or circulatory problems?
Yes No – Are you wearing contact lenses?	Yes No – Do you suffer from back pain?
Yes No – If "yes" to previous question, are you taking medication for this?	Yes No – Do you have numbness or stabbing pains anywhere?
Yes No – Do you have any allergies?	Yes No – Are you very sensitive to touch or pressure in any area?
Yes No – Do you suffer from epilepsy or seizures?	Yes No – Do you have any other medical condition I should be aware of?
Yes No – Do you suffer from joint swelling?	Comments:
Yes No – Do you have varicose veins?	
Yes No – Have you ever had surgery?	
Yes No – Do you have any contagious disease?	
Yes No – Do you have osteoporosis?	

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. 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 this 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 the massage or 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 specialty for any metal or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or metal illness, and that nothing said in the course of the session given should be construed as such. Because massage/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 forget to do so. It is also understood 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.

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

INFORMED CONSENT FOR MANUAL & ELECTRIC ACUPUNCTURE

I, _____ hereby authorize the use of manual and electric acupuncture upon myself (or my ward, _____), by _____.I understand that this method is considered experimental. Acupuncture has been explained to me as a medical treatment performed by the insertion of special needles (with or without the application of small pulses of electrical current to the needles), through the skin into the underlying tissue at certain indicated points of the surface of the body, for the purpose of the alleviation or cure of painful bodily diseases and disorders, or for the treatment of symptoms and diseases for which acupuncture is known to be effective. Manual and electric acupuncture have the potential beneficial and adverse effects:

Potential beneficial effects: 1) Varying degrees of relief from pains, including migraine headache, oral and facial pain, chronic joint pain, spastic muscles. 2) Relief from bronchial asthma, insomnia, emotional irritability disorders, nerve deafness. 3) Relief from constipation, diarrhea, ulcerative colitis, or other gastrointestinal disorders. 4) Relaxation of vaso-constricted blood vessels, and the subsequent vaso-dilation and improvement of circulation. 5) Enhanced drug uptake in diseases areas where micro -circulatory disturbances exist and very little drug is absorbed. 6) For the relief of withdrawal symptoms of drugs, compulsive habits of excessive eating, drinking alcohol, and smoking. 7) And for the alleviation or cure of high blood pressure, coma, specific color blindness, and other diseases or symptoms resulting directly or indirectly from circulatory disturbances.

Possible complications and disadvantages include: 1) Potential bacterial and viral infections. 2) Ecchymoses, micro-hemorrhages, hematoma in the tissues, pain and discomfort, numbness, weakness, fainting and nausea. 3) Potential breakage of needle and/or its retention. 4) Necrosis of tissue around electrodes. 5) Accidental malfunctions of power source used in electric acupuncture. 6) Maximum effects of acupuncture, such as enhanced drug uptake, may last from 3-24 hours, although other effects may last much longer. 7) Just like any other treatment, unforeseen adverse effects can occur, including worsening of symptoms, which may or may not be related to this treatment.

I have been made aware of the possibility of both complications and beneficial effects that may result from this procedure, and I indemnify the physician from any and all responsibility for such possible consequences. Hence, I will not blame or sue the physician, or the institute or location where such treatment was performed, concerning any consequence of the treatment. All my questions on this treatment and alternative methods of treatment have been answered, and all the treatment procedures have been explained in detail. I therefore authorize _____ to use either manual or electric acupuncture, to take photographs of myself before, during and after this treatment, to write the findings related to my condition and treatment directly on my body surface, and to photograph this for permanent medical records and possible reports for the medical community regarding the effectiveness of this treatment. Since this treatment was authorized by my free will, I am free to withdraw at anytime from further treatment using manual or electric acupuncture.

_____	_____	_____
Witness	Patient's or Guardian's Signature	Date

PATIENT'S NAME: _____

ARBITRATION AGREEMENT (ACUPUNCTURE), Page 2 of 2, PLEASE SIGN BOTH PGS

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether medical services were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as a back-up for the health care provider including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief , or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice

thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____ Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____

Patient's or Guardian's Signature Date