

Contract for Services to the client of
REFLEXOLOGY, METAMORPHOSIS (META) and/or
CRANIO SACRAL THERAPY (CST)

You need to know that:

- ~ I am not a doctor and I do not practice medicine
- ~ I do not diagnose, treat specific illnesses, prescribe or adjust medication
- ~ Reflexology, META, and/or CST are not a substitute for medical treatment

What is Reflexology?

Reflexology is a gentle non invasive complementary healing modality. It is based on an ancient science based on the premise that there are reflexes in the feet, hands, and ears. Stimulating these reflexes brings about self healing and balance.

What is Metamorphosis?

META offers a way to release underlying chronic tension by working the head and spine as well as the head and spinal reflexes on the feet and/or the hands. Meta does not treat or address symptoms. META brings about healing at the most primary level, that of the principal of life within us. Disease and discomfort cease to exist when the tension eases and/or goes away.

What is Cranio Sacral Therapy (CST)?

CST is a gentle, hands-on method of evaluating and enhancing the functioning of a physiological body system called the craniosacral system - comprised of the membranes and cerebrospinal fluid that surround and protect the brain and spinal cord. Using a soft touch, helps release restrictions in the CST system to improve the functioning of the central nervous system. CST is effective for a wide range of medical problems.

By signing this form, I give my consent to a Reflexology, META and/or CST session. I understand I may discontinue a session or sessions at any time. If I have been diagnosed by a licensed health professional as having any disease, injury or other physical or mental condition, I understand that I should inform the person who made the diagnosis about the sessions I will be receiving and whether or not I intend to discontinue any treatment or therapy which had been previously ordered, prescribed or recommended by the licensed health professional. I understand that by modifying or discontinuing any such treatment or therapy, I assume responsibility for any negative outcome thus resulting.

Signature: _____ Date: _____

Print Name: _____

Reflexology, META and/or CST are NOT a substitute for medical care. If you are experiencing any specific medical condition and have not seen your medical doctor, I recommend you do so ASAP.

Client Information and Assessment Form

Name: _____ DOB: _____
Address: _____ Cell: _____
Occupation: _____ Email: _____
Emergency contact - name and cell: _____

Present Health Concerns

Principal Diagnosis: _____
Diagnosed by: PCP/Specialist/Other _____
When Diagnosed: _____ Symptoms: _____
Current Medication/Treatments: _____
Have you ever tried Reflexology? _____ When/Where? _____
Have you ever tried META? _____ When/Where? _____
Have you ever tried CST? _____ When/Where? _____

Medical History (Please check all recurring issues)

<input type="checkbox"/> acne	<input type="checkbox"/> allergies	<input type="checkbox"/> asthma	<input type="checkbox"/> anxiety
<input type="checkbox"/> athlete's foot	<input type="checkbox"/> back pain	<input type="checkbox"/> bronchitis	<input type="checkbox"/> bruising
<input type="checkbox"/> constipation	<input type="checkbox"/> congestion	<input type="checkbox"/> common cold	<input type="checkbox"/> cold hands/feet
<input type="checkbox"/> depression	<input type="checkbox"/> diarrhea	<input type="checkbox"/> dizziness	<input type="checkbox"/> fatigue
<input type="checkbox"/> flu	<input type="checkbox"/> fluid retention	<input type="checkbox"/> gall stones	<input type="checkbox"/> gastric ulcer
<input type="checkbox"/> heartburn	<input type="checkbox"/> hives	<input type="checkbox"/> incontinence	<input type="checkbox"/> indigestion
<input type="checkbox"/> insomnia	<input type="checkbox"/> joint pain	<input type="checkbox"/> joint stiffness	<input type="checkbox"/> kidney stones
<input type="checkbox"/> laryngitis	<input type="checkbox"/> loss of hearing	<input type="checkbox"/> mood swings	<input type="checkbox"/> mouth ulcers
<input type="checkbox"/> muscle fatigue	<input type="checkbox"/> muscle pain	<input type="checkbox"/> nausea/change in appetite	
<input type="checkbox"/> numbness	<input type="checkbox"/> OB/GYN issues	<input type="checkbox"/> pneumonia	<input type="checkbox"/> prostate issues
<input type="checkbox"/> sciatic pain	<input type="checkbox"/> sinus problems	<input type="checkbox"/> sore throat	<input type="checkbox"/> swollen glands
<input type="checkbox"/> swelling	<input type="checkbox"/> tight chest	<input type="checkbox"/> TMJ	<input type="checkbox"/> urinary problems
<input type="checkbox"/> other _____			
<input type="checkbox"/> pregnant?	<input type="checkbox"/> 1st trimester	<input type="checkbox"/> 2nd trimester	<input type="checkbox"/> 3rd trimester

Please list previous operations/accidents:

Please list other complementary modalities in which you regularly participate (chiro, massage, etc.)
