CLIENT CONSENT TO TREAT & INTAKE FORM

DATE: _____ DATE OF BIRTH: _____

FULL NAME: _____

PHONE: _____ EMAIL: _____

ADDRESS: _____

SERVICE REQUESTED: _____

ARE YOU A VIP MEMBER? PLEASE CIRCLE MEMBERSHIP PLAN.

THE MONALISA THE ELITE THE VIP I'D LIKE MORE INFO!

YOUR MEDICAL HISTORY IS IMPORTANT FOR THE OUTCOME OF YOUR SERVICE. PLEASE CHECK ALL THAT APPLY.

MEDICAL HISTORY	YES or NO	List all Medication(s)	Comments
Recent surgery (date)			
History of blood clots			
History of Cancer			
History of Bruising			
Abnormal Bleeding			
Use of Blood Thinners			
Lymphedema			
Hernias			
Open of Infected wounds			
Sensitivity to cold or hot			
Hypertension			
Irregular Heartbeat (EKG)			
Ankle Swelling			
Kidney Disease			
Diabetes			
Uncontrolled Anxiety			
Congestive Heart Failure			
Known Allergies			
Other Conditions			

I, _____, consent to the above service(s) and have notified my provider on this form of any other concerns/issues that may impact my desired service(s).

_____ _____

Client Signature Date

_____ _____

Provider Signature Witness