CLIENT VIRTUAL CLINIC AGREEMENT FORM

Client must agree and sign this consent form before participating in the Evolve College Virtual Clinic.

I Amelia Beer *(client's full name)* of 5 Boundary Street *(client's address)*

have read the Evolve College Virtual Clinic client terms and conditions provided to me by my therapist and declare that I agree in full to the terms and conditions stated including that I am personally fully responsible for my participation in this treatment as part of the Evolve College Virtual Clinic and I acknowledge that my therapist is a student therapist and my participation is at my own risk.

By signing this I consent to my participation in the virtual clinic and agree in full to the Evolve College Virtual Clinic Client Terms and Conditions.

(If you have not read the terms and conditions request these from your student therapist. Evolve College does not permit you to participate in treatment unless you have read in full the Evolve College Virtual Clinic Client Terms and Conditions and agree to them).

Signature: AB Session Date: 29.4.23

Session Location: Narrabri Session Time: 12:55

Massage Therapist Name: Tenya

IMPORTANT: THIS SIGNED AGREEMENT FORM MUST BE DISPLAYED TO THE CAMERA (RECORDING DEVICE) BY THE CLIENT AT THE BEGINNING OF THE VIDEO RECORDING SESSION, BEFORE TREATMENT COMMENCES.

IMPORTANT NOTE:

THE SIGNED FORM MUST BE DISPLAYED TO THE CAMERA AT EVERY SESSION.

Client Intake Form - Therapeutic Massage

Client Information

Name Amelia Beer Email ameliabeer3@Hotmail

Phone (cell/day) 0417440821 DOB 24.8.03 Age: 19

Address _____ City/State/Zip _____

Emergency Contact Name _____ Phone _____ Relationship _____

Occupation Farmer Referred by: _____

Health Information

Are you taking any medications? ☐ yes ☑ no If yes, please list: _____

Any allergies? (oils, lotions, nuts, fruits, skin, etc.) ☐ yes ☑ no If yes, please list: _____

Are you pregnant? ☐ yes ☑ no If yes, how many months: _____ Due date: _____

Are you you currently under medical supervision or receiving other medical interventions? ☐ yes ☑ no

If yes, please describe: _____

Areas of swelling	yes (no)	Diabetes	yes (no)	Osteoporosis	yes (no)
Autoimmune disorder	yes (no)	Fibromyalgia	yes (no)	Phlebitis	yes (no)
Back / neck problems	(yes) no	Headaches	(yes) no	Sciatica	yes (no)
Bleeding disorders	yes (no)	Heart condition	yes (no)	Seizures	yes (no)
Blood clots	yes (no)	Hypertension	yes (no)	Stroke	yes (no)
Bruise easily	yes (no)	Kidney disease	yes (no)	Tendinitis	yes (no)
Bursitis	yes (no)	Multiple sclerosis	yes (no)	TMJ disorder	yes (no)
Cancer	yes (no)	Neurological condition	yes (no)	Varicose veins	yes (no)
Contagious condition	yes (no)	Neuropathy	yes (no)	Vertigo / dizziness	yes (no)
Decreased sensation	yes (no)	Osteoarthritis	yes (no)		

Areas of broken skin? (e.g. rash, wounds) ☐ yes ☑ no If yes, where? _____

History of joint replacement surgery? ☐ yes ☑ no Which joint(s) ? _____

Recent injuries or medical procedures in the past 2 years? ☐ yes ☑ no Please describe: _____

Please describe any other injuries or health conditions: _____

Massage Information

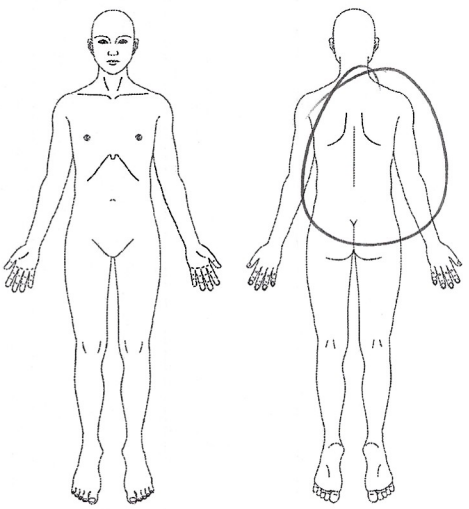
Have you had professional massage before? ☐ yes ☑ no How recently? _____

Reason for seeking massage: ☑ Relaxation ☐ Specific problem

_____

How much pressure do you prefer? ☐ Light ☑ Medium ☐ Firm

Please indicate any areas of discomfort



By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

Client Signature _____ Date 29.4.23

Therapist Signature _____ Date 29/4/2