Intake Form and Release of Liability

This waiver is for clients who will be participating in hands-on or verbally guided ABM Neuromovement lessons. The following information will be held in strict confidence. To help us be effective in working together, please be as specific as possible. Thank you.

Name: _____

Address: _____

City/Province _____

Postal Code: _____

E-Mail: _____

Occupation/Employer: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please circle which phone you prefer to be called on first.

Birth Date: _____

Referred by: _____

HEALTH HISTORY

What is bothering you at this time? _____

_____

Please describe any surgery, accident, or muscular/skeletal problem or pain that has required medical attention? _____

_____

Please describe any physical aides you use such as walker, wheelchair, etc. _____

_____

Please list any medications that you currently take: _____

_____

Hand dominance: Right _____ Left _____

Please describe any mental health concerns/issues you are dealing with/have been diagnosed with: _____

_____

Please indicate areas of concern and describe.

Arms/Wrists/Hands, R or L: _____

Back (Upper/Middle/Lower): _____

Shoulders: _____

Hips (R or L): _____

Legs (R or L): _____

Knees (R or L): _____

Feet (R or L): _____

Other: _____

Please check any of the following that apply to you:

____ Allergies/Asthma/Sinus

____ Athletes Foot

____ Arthritis

____ Autoimmune Disorder

____ Blood Clots

____ Bone/Joint Disease

____High/Low Blood Pressure

____Mastectomy: R____ L____

____Numbness/Tingling

____Pacemaker

____Phlebitis

____PMS

____Cancer

____Cardiovascular/Heart

____Chronic Pain

____Constipation

____Dentures

____Diabetes

____Digestive

____Dizziness

____Headaches

____Pregnant: Due: ____

____Respiratory/Lungs

____Sciatica

____Scoliosis

____Skin Disorders

____TMJ/Jaw Pain

____Varicose Veins

____Vision: Contacts____ Glasses ____

____Other medical conditions (specify)

FEMALE CLIENTS:

Pregnant_____Y, _____N If yes, Estimated due date: _____

Number of pregnancies:_____ Number of Births:_____

C-sections:_____ Vaginal Births:_____

Date of Delivery/ies:_____

Any concerns:_____

3 wishes/goals in working with Michelle Mark

1.

2.

3.

ALL CLIENTS:

Please initial the following and sign below

_____*I understand that the lessons given by Michelle Mark (hereafter the "Practitioner") are a way to open doors to new possibilities of movement and are educational only. They are not medical and do not take the place of appropriate medical care.*

_____ *I agree to let the Michelle Mark know immediately if I experience any discomfort or increased discomfort*

_____*I affirm that I have notified Michelle Mark of all known medical conditions and injuries and will inform her of any changes in my health and medical condition.*

_____*I understand that I am responsible for giving at least 24hr notice for any cancellation; otherwise, I am still responsible for payment for the missed lesson.*

In exchange for the ability to participate in these lessons,

_____ (*fill in your name here*) ("Releasor"), does hereby remise, release, and forever discharge Michelle Mark, as well as her agents, from all manner of actions, suits, proceedings, judgments, damages, claims, and demands in law or equity, which Releasor has or may have as a result of lessons or other services, supplies or instructions provided by or on behalf Michelle Mark.

In witness whereof, I have signed this Intake Form and Release of Liability this day of

_____ (date)

_____(Signature of Releasor)