STONE THERAPY CLIENT INFORMATION FORM

Stone Therapy is a powerful form of “Thermotherapy Treatment”. While the temperatures are strictly monitored, it remains the responsibility of the client to communicate any discomfort during the treatment. Failure to do so waves all liability to **REVITALIZING TOUCH** and the therapist.

DATE: _____

NAME: _____

ADDRESS: _____

CITY, PROVINCE & POSTAL CODE: _____

PHONE#: (Home) _____ (Work) _____

EMAIL: _____

DATE of BIRTH: _____

What are your main concerns, (area of pain or discomfort?) _____

_____

Please mark “C” (Currently) or “P” (Past) if you have, or have had, to your knowledge any of the following conditions:

Acute Infection _____
Allergies _____
Arthritis _____
Asthma _____
Bursitis _____
Back Pain _____
Cancer _____
Cardiovascular Disease _____
Chronic Infection _____
Cold Hands/Feet _____
Diabetes _____
Digestive Problems _____
Epilepsy _____
Fatigue _____
Fibrosis/Fibromyalgia _____

Headaches _____
Head or Neck Trauma _____
Hepatitis _____
High Blood Pressure_____
HIV _____
Joint Pain _____
Kidney Disease _____
Menstrual Cramps _____
Muscle Pain _____
Neck Pain _____
Pregnancy _____
Sore Feet _____
Spinal Disc Injury/Disease _____
Thrombosis (blood clots) _____
Other (Please Specify) _____

Are you taking any kind of medication? If yes, for what?

_____

Have you ever had a major accident, illness or surgery (particularly nerve damage) and if so, how, when and where?

_____

If injured did you use hot or cold? _____

What worked? _____ What didn't _____

Do you smoke? YES___ NO ___

What is your WATER intake? _____

Do you Exercise? YES ___ NO ___

What kind of Exercise do you do? _____

I _____ am aware of the extreme temperatures used in this treatment, and hereby consent to assume all responsibility to communicate the slightest bit of discomfort or pain if any, of these stones, releasing any and all liability or responsibility to the therapist and to REVITALIZING TOUCH.
I also agree to communicate a thorough report of my past and current condition.
I hereby agree that the risk of not communicating any discomfort during any point in this treatment has been explained to me and that failure to do so waves all responsibility to REVITALIZING TOUCH and to the therapist.

Signed _____

Date _____