Client Consultation & Consent Form

flow PRESSO

PERSONAL INFORMATION

FULL NAME:	
DATE OF BIRTH:	FEMALE / MALE / NB
ADDRESS:	
CITY & ZIP CODE:	OCCUPATION:
E-MAIL:	PHONE:
NAME OF DOCTOR:	MEDICAL PRACTICE:
WHERE DID YOU HEAR ABOUT US / REFERRED BY:	
( ) YES, I WOULD LIKE TO RECEIVE EMAILS AND SMS COMMUNICATIONS	

MEDICAL HISTORY

( ) Congestive Heart Failure	( ) Deep Vein Thrombosis (DVT)
( ) Arterial Dysregulation	( ) Pulmonary Embolism
( ) Carcinoma	( ) Acute Inflammatory skin diseases or infection
( ) Pulmonary Edema	( ) Circulation or vascular conditions
( ) Pregnant	( ) Raynard's Disease
( ) Diabetic	( ) Severe arteriosclerosis, or active infection
( ) Decompensated cardiac insufficiency	( ) Surgery (in the last year)
( ) OTHER	

MEDICINES / SUPPLEMENTS

LIFESTYLE

On a scale of 1-5, rate your health: 1 = Very well, 5 = Very Unwell
On a scale of 1-10, how would you rate your current stress level? 1 = No Stress
Do you have any sleep disorders or difficulties sleeping?
How many hours sleep do you get per night?
How much water do you drink on an average day?
Have you been diagnosed with any mental health conditions (e.g., anxiety, depression)?
Do you experience fluid retention? If so, where and how often?
Have you been prescribed diuretics or other medications for fluid retention?
How often do you engage in physical exercise (e.g., daily, weekly, rarely)?
Have you had any recent skin infections or wounds?
Have you previously received lymphatic drainage therapy or similar treatments?
What are your primary goals for using Flowpresso (e.g., relaxation, pain relief, overall wellness)?

INFORMED CONSENT & LIABILITY RELEASE

Terms of Engagement and Consent:

By signing this Informed Consent and Liability Release I understand that:

- I have provided accurate recount of my health history and will update this Clinic and of employees working here, of any and all changes to my health and wellness. I also agree that I have received a full explanation of the treatment program and any possible consequences. As with any practice involving the body a particular course of action my have varying degrees of success and the duration of the treatment, to achieve a particular result.
- This treatment does not replace any treatment currently prescribed by your doctor nor prescribed medication you are taking.
- I am recommended to drink one glass every hour for 3 hours following my Flowpresso session, to minimise and side effects for eg:, dehydration or headache.
- The Clinic will not be liable for any side effects, adverse reactions or lack of perceived benefits suffered by you or other consequences as the result of the treatment, and you excuse the Clinic and all its employees from all liability.
- I understand Flowpresso does have contraindications and I have been informed of these.

I have fully read this Informed Consent and Liability Release Form in its entirety and hereby execute it freely and have full acceptance and knowledge of the contents in it. I also understand that this is a legal document.

Signed:

Date:

OFFICE USE