CLIENT VIRTUAL CLINIC AGREEMENT FORM

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

I Alexandra Mason (*client's full name*) of Tamleigh Narrabri (*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: AMason Session Date: 24.10.23

Session Location: Narrabri Session Time: _____

Massage Therapist Name: Tanya

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.

Massage Intake Form

Personal Information

Name Alex Mason Phone (day) 0498733596 (evening) _____

Address "Thornleigh" City/State/Zip Nambucca 2390 DOB 28.6.89

Occupation Admin Employer CUC NW

Email alexandramason1989@outlook.com Primary Physician _____

Emergency Contact Kane Mason Relationship husband Phone 0478928784

How did you hear about us? WCVC.

Medical Information

Are you taking any medications? ☐ yes ☑ no

If yes, please list name and use: _____

Are you currently pregnant? ☐ yes ☑ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☑ no

If yes, please explain _____

What makes it better? _____

What makes it worse? _____

Have you had any orthopedic injuries? ☐ yes ☑ no

If yes, please list: _____

Please indicate any of the following that apply to you.

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☑ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains

Explain any conditions you have marked above:

Gestational diabetes

Massage Information

Have you had a professional massage before? ☑ yes ☐ no

What type of massage are you seeking?

☐ Relaxation ☑ Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

☐ Light ☑ Medium ☑ Deep

Do you have any allergies or sensitivities? ☐ yes ☑ no

Please explain _____

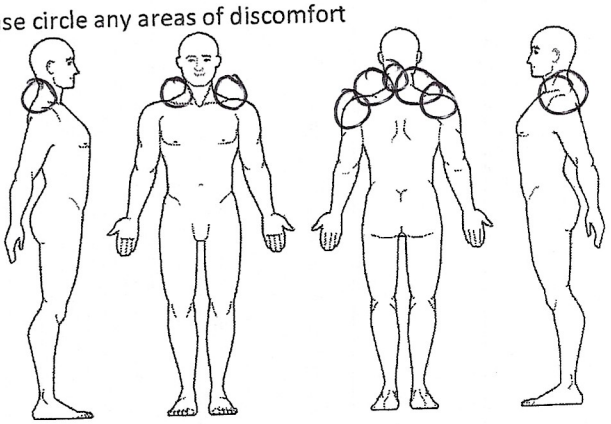
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature Amason *Date* 26.10.23

Therapist Signature _____ *Date* _____