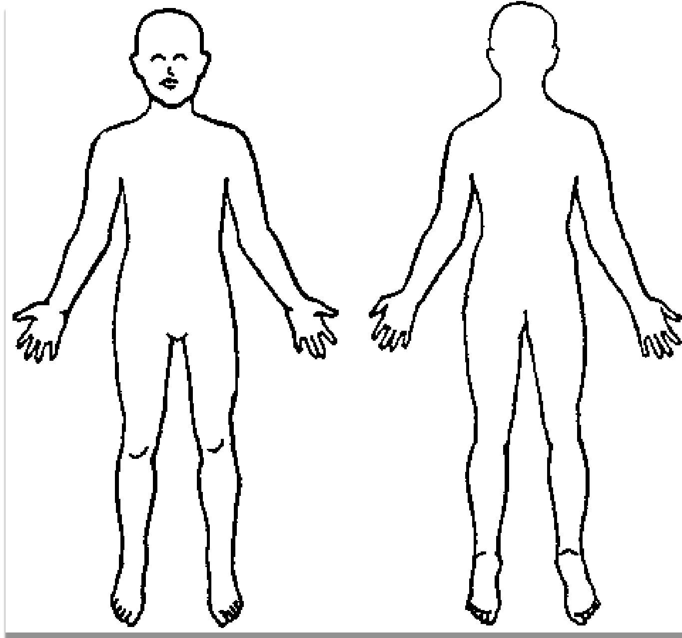
DATE:_____________________ NAME:____________________________
EMAIL:_________________________________ DOB:____________

Background Information

Please list any medical conditions you have: ____
____
____

Have you had any significant life changes in the past 12 months? ________________________________
____

Please mark any areas of concern:



Describe what you feel : ________________
____
____
____
____

What would you like to gain from your wellness visits? _______________________
____
____
____

What part of your life was interrupted by your symptoms? ______________________
____
____
____
____

How did you hear about me/Into the Light?____

HIPAA/PHI Disclosure

I, _______________________________, understand that Into the Light Healing and Bodywork, LLC protects my information and will not disclose anything without my signature that follows. This information would only be used to optimize my care and my case discussed only with other health care providers already familiar with me, given my permission below.

X____ Date:____________________

DATE:______________________ NAME:______________________________

EMAIL:__________________________________ DOB:____________

Consent for Treatment

Common Material Risks: Increased global soreness, general fatigue, muscle aches/fatigue/strains, bowel/bladder function/movement, change in mood/emotions, irritated/inflamed joint, fall over (yoga).

I, _______________________________, do hereby agree and give my consent for Kristin K. Smith to perform evaluation and treatment for general wellness on myself as she may deem reasonably necessary or desirable. I waive all liability, release all claims and acknowledge that **no guarantees or assurances have been made to me** as to results of my treatments. I understand that during Yoga or Craniosacral therapy sessions, light touch may be applied to different areas of my body. I will immediately communicate with Kristin regarding any hand placement that makes me uncomfortable so we can work together to find an alternative for my optimal healing.

I acknowledge that the services and treatments offered are not an exact science and that the outcome and/or result of any services and treatments are not known. While routinely performed without incident, there may be material risks associated with the services and treatments. Patient understands that it is not possible to list every risk for every service and that this form only attempts to identify the most common material risks. I understand that there may be alternatives to the services offered. I also understand that various professionals may have differing opinions as to what constitutes material risks and alternative services.

I understand that Kristin will rely on my documented medical history, as well as other information obtained from me; therefore, I agree to provide accurate and complete information about my medical history and conditions. I agree to provide a written update of my medical history whenever there is a change.

By signing this form I consent to treatments and services as may be deemed reasonably necessary or desirable in the exercise of Kristin's professional judgment, including those treatments and services that may be unforeseen or not known to be needed at the time this consent is obtained; and I acknowledge that I have been informed in general terms of the nature and purpose of the treatments and services; the material risks of the treatments and services, and practical alternatives to the treatments and services. If any issues arise during the course of my treatment or if I have complaints I agree to disclose the complaints and issues to Kristin in writing within two weeks of occurrence or prior to my next appointment, whichever is sooner so that appropriate corrections and decisions may be made.

X____ Date: ____________________