Full Name _____ Date _____

Informed Consent, Client & Therapist Information

Massage Therapist: *Thomas Liberto* **License #:** *MA3690*

Client Information

Name: _____ **Phone: (____)** _____ **-** _____

Address: _____ **Apt#:** _____

City: _____ **State:** _____ **Zip:** _____ **Date of Birth:** _____

E -Mail: _____

Occupation: _____ **Referred by:** _____

In case of emergency: _____ **Phone: (____)** _____ **-** _____

General & Medical information:

if you answer "yes" to any of the following questions, please explain as clearly as possible.

☐Yes ☐No	Have you ever had professional massage?	☐Yes ☐No	Have you had any broken bones in the past two years?
☐Yes ☐No	Do you experience frequent headaches?	☐Yes ☐No	Do you have tension or soreness in a specific area?
☐Yes ☐No	Are you pregnant?	☐Yes ☐No	Do you have cardiac or circulatory problems?
☐Yes ☐No	Are you wearing contact lenses?	☐Yes ☐No	Do you suffer from back, neck, leg or head pain?
☐Yes ☐No	Are you diabetic?	☐Yes ☐No	Do you have numbness or stabbing pains anywhere?
☐Yes ☐No	Do you have high blood pressure?	☐Yes ☐No	Are you very sensitive to touch / pressure in any area?
☐Yes ☐No	If yes to the previous question, are you taking medication for high blood pressure?	☐Yes ☐No	Have you ever had surgery? If yes, please explain In the comments area of this form.
☐Yes ☐No	Do you suffer from seizure disorders or epilepsy?	☐Yes ☐No	Do you have any other medical condition(s) that I should be aware of?
☐Yes ☐No	Do you suffer frequently from stress?	☐Yes ☐No	Please list below any medications you are taking

☐Yes ☐No Have you been injured in an auto accident? If yes, Date: _____ State: ____ Are you being treated for this now? ☐Yes ☐No

☐Yes ☐No Have you had an on the job injury? If yes, Date: _____ State: _____ Are you being treated for this now? ☐Yes ☐No

USE OTHER SIDE IF NECESSARY TO CONTINUE COMMENTS:

Comments: _____

_____

PLEASE TAKE A MOMENT TO CAREFULLY READ THE FOLLOWING INFORMATION AND SIGN WHERE INDICATED.

If you have a specific medical condition or specific symptoms, Massage Therapy may be contraindicated A referral from your primary care provider may be required prior to service being provided. I understand that the Massage Therapy I receive is provided for the basic purpose of relaxation and relief of muscular pain and tension. If I experience any pain or discomfort during this session, I immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that Massage Therapy should not be construed as a substitute for a medical examination/diagnosis, or treatment and that I should consult a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that Massage Therapy therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness unless prescribed by a qualified medical professional, and that nothing said in the course of the session given should be construed as such. Because Massage Therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and I have followed my doctor's orders or suggestions for further medical testing, I have answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I neglect to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in Immediate termination of the session and I will be liable for payment of the scheduled appointment I further agree should I obtain an attorney to pursue any collection of medical expenses I will immediately provide my attorney's name and contact information to my Massage Therapist listed above. I hereby provide my signature as agreement to the above and for consent to receive Massage Therapy services or medically necessary treatment by my physician's prescription.

Client Signature: _____ Date: _____

Full Name _____ Date _____

Therapist Signature: _____ Date: _____

Health/Medical Questionnaire

Present/Past History

Have you had OR do you presently have any of the following conditions? (Check if yes.)

☐Yes ☐No Rheumatic fever
☐Yes ☐No Recent operation
☐Yes ☐No Edema (swelling of ankles)
☐Yes ☐No High blood pressure
☐Yes ☐No Injury to back or knees
☐Yes ☐No Diabetes: ☐Type 1 or ☐Type 2
☐Yes ☐No COPD (chronic bronchitis or emphysema)
☐Yes ☐No Asthma
☐Yes ☐No Chest pains
☐Yes ☐No Fainting or dizziness with or without physical exertion
☐Yes ☐No Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) nocturnal dyspnea (shortness of breath at night)
☐Yes ☐No Palpitations or tachycardia (unusually strong or rapid heartbeat)
☐Yes ☐No Intermittent claudication (calf cramping)
☐Yes ☐No Pain, discomfort in the chest, neck, jaw, arms, or other areas with or without physical exertion
☐Yes ☐No Other

☐Yes ☐No Low blood pressure
☐Yes ☐No Seizures
☐Yes ☐No Lung disease
☐Yes ☐No Heart attack
☐Yes ☐No High cholesterol
☐Yes ☐No Stroke
☐Yes ☐No Kidney Dysfunction
☐Yes ☐No Liver Dysfunction
☐Yes ☐No Thyroid condition: ☐Hypo or ☐Hyper
☐Yes ☐No Unusual fatigue or shortness of breath with usual activities
☐Yes ☐No Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body
☐Yes ☐No Shortness of breath or chest pain at rest or with mild exertion
☐Yes ☐No Known heart murmur

Family History

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? In addition, please identify at what age the condition occurred.

☐Yes ☐No Heart arrhythmia: _____
☐Yes ☐No Heart attack: _____
☐Yes ☐No Heart operation: _____
☐Yes ☐No Congenital heart disease: _____
☐Yes ☐No Premature death before age 50: _____
☐Yes ☐No Significant disability secondary to a heart condition: _____
☐Yes ☐No Marfan Syndrome: _____
☐Yes ☐No High blood pressure: _____
☐Yes ☐No High cholesterol: _____
☐Yes ☐No Diabetes: _____
☐Yes ☐No Other major illness: _____

Full Name _____ Date _____

Health/Medical Questionnaire (Cont)

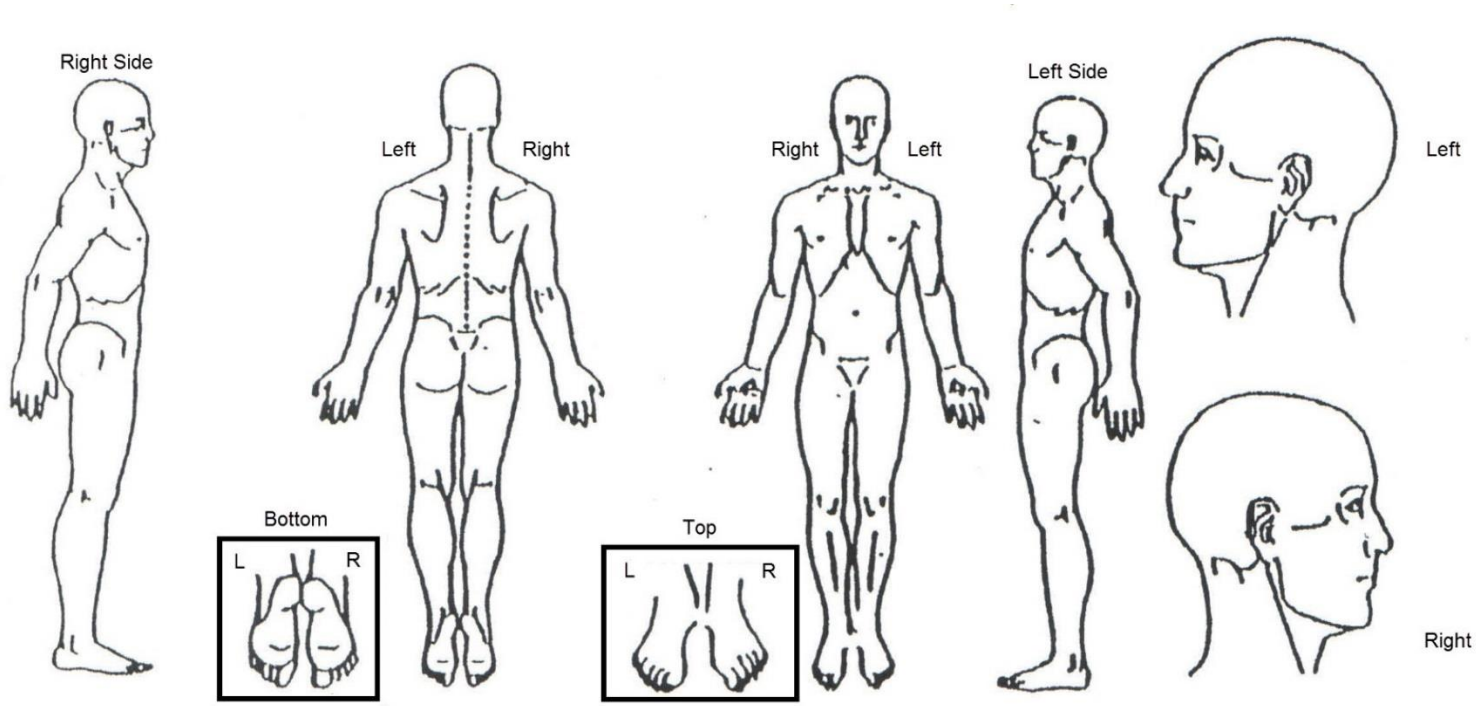
Activity History

1. Why are you enrolling in this program? _____
   _____
   _____
2. Are you presently employed? Yes ___ No ___
3. What is your present occupational position? _____
4. Have you ever worked with a personal trainer before? Yes ___ No ___
5. Date of your last physical examination performed by a physician:
6. Do you participate in a regular exercise program at this time? Yes ___ No ___ If yes, briefly describe:
   _____
   _____
7. Can you currently walk 4 miles briskly without fatigue? Yes ___ No ___
8. Have you ever performed resistance training exercises in the past? Yes ___ No ___
9. Do you have injuries (bone or muscle disabilities) that may interfere with exercising? Yes ___ No ___ If yes, briefly describe: _____
   _____
   _____
10. What is your body weight now? _____ What was it one year ago? _____ At age 21? _____
11. Do you follow or have you recently followed any specific dietary intake plan, and in general how do you feel about your nutritional habits? _____
12. List the medications you are presently taking. _____
    _____
13. List in order your personal health and fitness objectives.
    _____
    _____
    _____

Full Name _____ Date _____

Pain Identification Chart

Please mark your problem areas



Zero (0) equals NO pain and ten (10) equals EXTREME pain. How much pain are you experiencing today?

Circle the Appropriate response:

0 1 2 3 4 5 6 7 8 9 10

Please list or describe any additional symptoms you are experiencing in the space below:

Full Name Date

Informed Consent For Infrared LASER Therapy

Laser therapy is a safe and effective therapy that is FDA cleared for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Laser also promotes relaxation of muscle spasm and promotes vasodilation. Adverse effects from laser therapy are normally rare and temporary.

Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks. However, your results may be minimal or insignificant. Adverse effects of laser therapy may occur from multiple causes including hypersensitivity, preexisting health conditions, thermal effects, excessive pressure from the probe, and laser overstimulation. Laser light can damage the retina in your eye. Always wear the laser protective glasses provided.

The most common adverse effects are:

1. Temporary increase in pain during application of laser.
2. Temporary increase in pain the following day after laser therapy.
3. Mild bruising from vasodilation or direct pressure of laser tip.
4. Temporary dizziness.
5. Reactions when photosensitizing drugs are used with laser therapy.

I understand the risks of laser therapy and agree to the treatment program outlined by my doctor and/or therapist.

Patient Signature: _____ Date: _____

Please Print Name: _____

Date of Birth: _____

Full Name Date

Waiver And Release And Assumption Of Risk Agreement

In consideration of me being permitted to participate in any way in the Thomas Liberto, NSCA-CPT, Personal Training Activities ("Activity"), I agree:

1. I understand the nature of **Strength & Conditioning or Personal Training** activities and believe I am qualified to participate in such Activity. I further acknowledge that I am aware the activity will be conducted at my home or in a studio during the Activity. I further agree and warrant that if at any time I believe conditions to be unsafe, I will immediately discontinue further participation in the Activity.

2. I FULLY UNDERSTAND that: (a) Strength & Conditioning and Personal Training Activities involve risks and dangers of **SERIOUS BODILY INJURY, INCLUDING PERMANENT DISABILITY, PARALYSIS AND DEATH** ("Risks"); (b) these Risks and dangers may be caused by my own actions, or inaction's, the actions or inactions of others participating in the Activity, the condition in which the Activity takes place, or THE NEGLIGENCE OF THE "RELEASEES" NAMED BELOW; (c) there may be other risks and social and economic losses either not known to me or not readily foreseeable at this time; and **I FULLY ACCEPT AND ASSUME ALL SUCH RISKS AND ALL RESPONSIBILITY FOR LOSSES, COSTS, AND DAMAGES** incurred as a result of my Participation in the Activity

3. **I HEREBY RELEASE, DISCHARGE, COVENANT NOT TO SUE, AND AGREE TO INDEMNIFY AND SAVE AND HOLD HARMLESS** Thomas Liberto, NSCA-CPT, any respective administrators, directors, agents, officers, volunteers, and employees, other participants, any sponsors, advertisers, and if applicable, owners and lessors of premises on which the Activity takes place (each considered one of the "Releasees" herein) from all liability, claims, demands, losses, or damages on my account caused or alleged to be caused in whole or in part by the negligence of the "Releasees" or otherwise, including negligent rescue operations and further agree that if, despite this release, I, or anyone on my behalf makes a claim against any of the Releasees named above, **I WILL INDEMNIFY, SAVE AND HOLD HARMLESS EACH OF THE RELEASEES FROM ANY LITIGATION EXPENSES, ATTORNEY FEES, LOSS LIABILITY, DAMAGE OR COSTS ANY MAY INCUR AS THE RESULT OF ANY SUCH CLAIM.**

I HAVE READ THIS AGREEMENT, FULLY UNDERSTAND IT'S TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT AND HAVE SIGNED IT FREELY AND WITHOUT ANY INDUCEMENT OR ASSURANCE OF ANY NATURE AND INTEND IT TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW AND AGREE THAT IF ANY PORTION OF THIS AGREEMENT IS HELD TO BE INVALID THAT THE BALANCE, NOTWITHSTANDING, SHALL CONTINUE IN FULL FORCE AND EFFECT.

Printed Name of Participant | Signature of Participant | Date