

Information Form

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Phone(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I understand that the information I give on this form will be confidential and will be used for no other purpose than treatment and session protocol.
* I understand that the services offered by Fossé Restorative Therapy are not a substitute for medical care. If I experience any pain or discomfort during my session, I agree to inform the practitioner immediately, so that the exercise or massage technique may be adjusted to my level of comfort. \_\_\_\_\_ **Please initial**
* I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.
* It is understood that the services I receive are strictly therapeutic and non-sexual in nature.
* I understand I am financially responsible for my appointments and that the payment is due at the time of service. \* \_\_\_\_\_ **Please initial**
* I agree to provide 24-hour cancellation notice. If I fail to do so, I agree to pay the full appointment fee. \_\_\_\_ **Please initial.**

**Medical history**

List medications/herbs/vitamins, dosage and reason/purpose:

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | High blood pressure |  | Orthopnea |
|  | Low blood pressure |  | Nocturnal dyspnea |
|  | Blood clots (DVT) |  | Shortness of breath at rest or with mild exertion |
|  | Varicose veins |  | Chest pain or pressure |
|  | Edema |  | Palpitations or tachycardia |
|  | phlebitis |  | Pain, discomfort in chest, neck jaw, arms, or other |
|  | lymphedema |  | Heart attack |
|  | Rheumatic fever |  | Heart murmur |
|  | neuropathy |  | Unusual fatigue or shortness of breath with normal activities |
|  | Numbness/tingling |  | Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, leg |
|  | arthritis |  | Lung disease |
|  | Cancer/tumors: |  | Seizures |
|  | headaches |  | Fainting or dizziness |
|  | sinus problems |  | epilepsy |
|  | Migraine headaches |  | glaucoma |
|  | Intermittent claudication (leg or hip cramping) |  | Diabetes |
|  | Muscles/joints pains |  | High cholesterol |
|  | Sprains/strains |  | Sleep difficulty |
|  | Injury to back or knees |  | Depression - |
|  | Chronic pain |  | skin problems. Specify: |
|  | Tendonitis |  | Jaw pain/teeth grinding |
|  | Whiplash |  | Allergies: |
|  | Scoliosis |  | Women only: |
|  | Surgeries, recent or old |  | pregnant |
|  |  |  | Endometriosis |
|  | Other: |  | Painful menstruation - |
|  | Other: |  |  |

Agreement of Release and Waiver of Liability

This form covers all services offered by Fossé Restorative Therapy, LLC. Please fill out the following, being sure to read each paragraph.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby agree to the following:

that I am participating in Restorative Therapy sessions with Fossé Restorative Therapy, LLC, during which I receive information and instruction about healthy and safe practice. I recognize that these sessions may require physical exertion, which may be strenuous and could result in physical injury, and I am fully aware of the risks ad hazards involved.

I understand that it is my responsibility to consult with a physician prior to and regarding my participation in Restorative Therapy sessions.

I agree to assume full responsibility for any risks, injuries or damages, known or unknown, which I might incur as a result of participating in the program. I agree to inform my instructor/teacher of any physical limitations, physical discomfort and/or injuries before or during classes, and I take full responsibility for nondisclosure.

In further consideration of being permitted to participate in Restorative Therapy sessions, I, my heirs and legal representatives knowingly, voluntarily and expressly waive any claim I may have against Fossé Restorative Therapy, LLC for injury or damages that I may sustain as a result of participating in this program.

I have read the above release waiver of liability and fully understand its contents. I voluntarily agree to its contents. I voluntarily agree to the terms and conditions stated above.

Signature of Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_

If participant is under 18:

As legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I consent to the above terms and conditions.

Signature of Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_

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