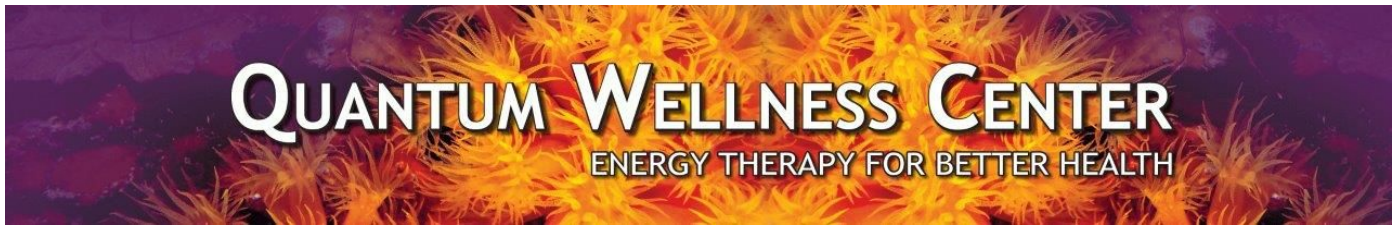


CLIENT INFORMATION FORM

Page 1

Name: _____

Phone (day): _____ (evening): _____

Cell: _____

Mailing Address: _____

City, State, Zip: _____

E-Mail: _____ Date of Birth: _____

Would you like to be added to our mailing list? Yes No

Occupation: _____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

General Information

How did you hear about us? If referred, by whom? _____

Are you presently under a doctor's or therapist's care? If so, for what and by whom?

_____

Have you ever had Reiki, Sound Therapy or any energy work before? Yes No

If yes, for what purpose? (general wellness, stress reduction, specific ailment, etc.)

_____

What kind of experiences and/or results did you have?

_____

What do you hope to accomplish with this session?

Relaxation Stress Reduction Pain Reduction Other (please explain)

_____

Are you sensitive to fragrances or perfumes? Yes No

What are your common areas of pain or tension?

_____

Do you meditate regularly? Yes No Do you exercise regularly? Yes No

List any specific areas you would like the practitioner to concentrate on during the session.

_____

Do you have any concerns related to your session or is there anything else we should know?

_____

CLIENT INFORMATION FORM

Page 2

Please check any of the following which apply. Some may be contraindications for some types of bodywork.

☐ Contact Lenses	☐ Asthma	☐ Mood Swings
☐ Aids	☐ Sprain	☐ Sleep Disorders
☐ Hepatitis	☐ Fracture	☐ Exhaustion
☐ Varicose Veins	☐ Foot Pain	☐ Depression
☐ Blood Clots	☐ Numbness	☐ Acute Anxiety
☐ Stroke	☐ Headaches	☐ Osteoporosis
☐ Heart Attack	☐ Low Back Pain	☐ Slipped Disc
☐ High/Low Blood Pressure	☐ Pregnant	☐ Pacemaker
☐ Diabetes	☐ Herpes	☐ Other:_____
☐ Hypoglycemia	☐ Cancer	_____
☐ Allergies	☐ Arthritis	_____
☐ Weakness/Coldness or	☐ Torn Ligaments/	_____
☐ Numbness in Limbs	☐ Cartilage/Tendons	_____

I, _____, understand that an Energy / Sound Therapy session is not a substitute for physical, psychological or mental diagnosis and/or treatment. The Practitioner does not diagnose conditions, does not perform any medical treatment, does not prescribe substances, does not and will not interfere with the treatment of any licensed medical professional. It is recommended that I see a licensed physician or licensed health care professional for any psychological or physical ailment that I have.

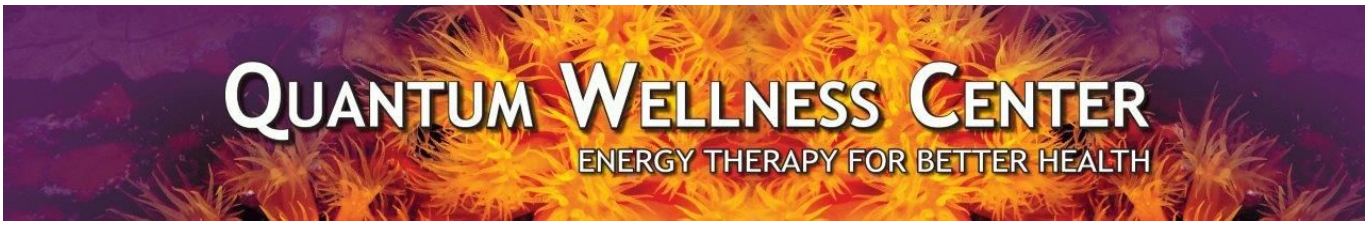
_____ _____

Client Signature Date

_____ _____

Guardian Signature Date

Practitioner's Name: T Love, RHP, CVST, CPPP, EPP



APPOINTMENT POLICIES

- Each session is allotted a specific amount of time
- The first appointment, which includes a history and an assessment, lasts approximately 15 minutes longer than the normally allotted time for a session
- If a client is late for a treatment session, the session still falls within the allotted time frame
- If I am late, the entire time for the session will be complete
- Telephone calls are not taken during sessions
- Cell phones must be turned off or placed in airport mode during sessions
- If you wish to cancel an appointment, you must do so 24 hours in advance, or you are charged for the full amount of the session unless the appointment can be filled
- If I need to cancel an appointment, I will do so within 24 hours whenever possible.
- Appointments are held at 4 Hidden Valley Road, Andover Township, New Jersey
- For those clients who are not ambulatory, house call visits, or distance sessions, may be arranged
- Telephone calls and/or e-mails will be responded to within 24 hours unless I am out of town.
- In the case of an emergency, treatment will be offered within 24 hours of contact.

FEES

- If, during my assessment, I determine with reasonable certainty that my work won't help you, we end the session at that time and you are not charged for the initial appointment
- Payment is due at the time of service unless other arrangements have been made prior to treatment
- I do not bill clients nor do I provide direct billing for insurance
- Payments must be made in the form of either cash or a check
- I do not accept credit cards

PROFESSIONALISM

- Our profession subscribes to a Code of Ethical Behavior
- I follow all the statements in this ethical code and have strong beliefs that practitioners and their clients should not engage in intimate social relationships
- Personal and professional boundaries are respected at all times.
- The client is always fully clothed so draping is not an issue. However, if you feel a chill or would like to add an extra level of comfort, a blanket will be provided
- I perform services for which I am qualified (professionally, physically and emotionally) and able to do, and refer to appropriate specialists when work is not within my scope of practice or not in the client's best interest
- I customize my treatments to meet the client's needs
- I keep accurate records and review changes before each session
- I respect all clients regardless of their age, gender, race, national origin, sexual orientation, religion, socioeconomic status, body type, political affiliation, state of health or personal habits

ETIQUETTE

- Please do not wear any heavy perfume, lotion or after shave
- There is no smoking allowed on the premise
- Arriving in an altered state or under the influence of alcohol or drugs will not be tolerated
- If you are sick and may be infectious, please call ahead so we may discuss the situation.

CONFIDENTIALITY

- First and foremost, the issue of confidentiality concerns the client's rights to privacy and safety
- These rights belong equally to every client I see regardless of age, gender, race, national origin, sexual orientation, religion, socioeconomic status, body type, political affiliation, state of health or personal habits
- I believe these rights apply to both verbal and written interactions I have with everyone
- In the therapeutic setting, all that occurs remains private and protected

_____ _____

Client Signature Date

_____ _____

Guardian Signature Date

QUANTUM WELLNESS CENTER
ENERGY THERAPY FOR BETTER HEALTH

INFORMED CONSENT FORM

I, _____ hereby voluntarily request and consent to receive Integrative Holistic Healthcare services from T Love, RHP, CVST, CPPP, EPP.

I understand and acknowledge that no guarantees have been made to me as to the effect of such services.

I further understand and acknowledge that in no way are these services meant to be construed by me as the diagnosis or treatment of disease, but rather as an aid to balancing my energy and to possibly improving my general wellness.

I understand that prior to my first session; I will receive an oral explanation of and description of a session. I understand that I may refuse any, and all, services at any time during my first session or during any subsequent sessions.

I understand that, T Love, upholds the highest standards of care and professionalism and as a registered professional with the *British Academy of Sound Therapy*, *International Association of Reiki Professionals, the International Sound Therapy Association*, and *Sound Healers Association*, adheres to all requirements and codes of ethics.

I understand that Energy Therapy is not a substitute for medical treatment or medications, and it is recommended that I concurrently work with my Doctor or Primary Caregiver for any condition I may have. I am advised that if I am sick, I should consult my Doctor. I am aware that T Love does not diagnose illness or disease and does not prescribe medication.

If I experience any discomfort during the session, I will immediately communicate that to the practitioner so the treatment can be adjusted.

_____ _____

Client Signature Date