

Confidential Client Information

Name:		Date of Birth:	
Address:			
		Zip:	
E-mail:			
Home Phone:	Work Phone:	Cell Phone:	
Please circle any conditions that	at apply to you:		
Allergies Arthritis/Joint Discomfort Blood Clots Cancer Diabetes Flu/Cold Fever Please list any injuries and/or s	Heart Conditions High Blood Pressure Infection Kidney Dsyfunction Migraines/Headaches Neck/Spine Injuries urgeries and their dates:	Osteoporosis/Osteopenia Respiratory Disorder Skin Condition Tendinitis TMJ Other:	
Please list any medications or s	supplements you are currently taking	ing:	
Please list your main reason(s),	/goals for your massage:		

Core Elements Courtesy Conduct:

Cancellations - A minimum of 24 hours notice is requested to cancel or change an appointment. Appointments missed will be charged at full price.

Cell Phones – We ask that all phones are turned off for the relaxation of all clientele.

Gift Vouchers – Are non-refundable and must be produced at the time of your treatment. Vouchers are valid for 6 months from date of purchase.

PLEASE READ THE FOLLOWING WAIVER AND INFORMATION: I am aware of the benefits and risks of massage and give my consent for this and all consecutive treatments. I further understand that massage should not be construed as a substitute for a medical examination, or treatment and I should see a physician, or other medical professional for any ailment I am aware of. I affirm I have stated all my known medical conditions and answered the questions honestly. I agree to update the practitioner as to any changes in my medical profile. I understand there shall be no liability on the practitioners part should I forget to do so. I waive any claims and do hereby agree that I will not hold Core Elements LLC, or Claire Berresford, responsible for damages, ill effects, injury or illness that I may incur from receiving this therapeutic massage.

Signature: _____ Date: _____

Core Elements LLC 3001 Hungary Spring Road, Suite C, Richmond, VA 23228