Intake & Consent Form for Relaxation Therapy at Shift Date _____

Name _____ Age_____ DOB_____

Phone _____ Cell _____ Email _____

Address _____

City/State/Zip_____Sex: F[] M[]

Occupation _____

Emergency Contact Name _____Cell_____

Relationship to client _____

The following information will be used to help plan safe and effective Relaxation Therapy sessions. Please answer the questions to the best of your knowledge.

What is your goal for today's session? _____

List any Allergies or Sensitivities: _____

Are you currently under medical supervision? Yes [] No [] Explain if yes _____

_____

_____

Please list any medications you are currently taking? _____

_____

_____

Women Only: Pregnant? Yes [] No [] If yes, due date _____

Do you have a Seizure Disorder Yes [] No []

Do you have any Implants (teeth, stents, breast, etc) Yes [] No [] If Yes: Explain

_____

Family and home status (single, married, divorced, how many kids, ages, etc)_____

_____

_____

Please list anything else about your health history that you think would be useful for your practitioner to know to plan effective sessions for you.

_____

_____

Therapeutic elements such as sound, subtle vibration or scents may be included to support relaxation and integration. Please check the box if you're comfortable with using any of these elements during your session:

□ Smudge □ Sound □ Vibration □ Scents

Informed Consent & Liability Release

I understand that Relaxation Therapy is a non-medical, holistic practice intended to support relaxation, stress reduction, and nervous system regulation. It is not a substitute for medical diagnosis, treatment, or mental health care. I acknowledge that Relaxation Therapy practitioners at Shift Studio do not diagnose conditions, prescribe medications, or perform medical or psychological treatment. I understand that I am responsible for seeking care from a licensed medical or mental health professional for any condition requiring such attention. I agree to communicate openly during my session and to immediately inform the practitioner of any discomfort, pain, or emotional distress so that appropriate adjustments can be made. I understand that I may request to pause or end the session at any time. I affirm that I have disclosed all relevant health information accurately and completely. I agree to notify Shift Studio of any changes to my health status prior to future sessions. I voluntarily assume full responsibility for my participation in Relaxation Therapy sessions and hereby release, waive, and hold harmless Shift Studio, its owners, employees, contractors, and practitioners from any and all claims, liability, or damages arising before, during, or after my session. I understand that Relaxation Therapy is performed while fully clothed and involves gentle, respectful touch on a treatment table. I acknowledge that payment is required at the time services are rendered and that sessions are complementary in nature. By signing below, I confirm that I have read, understand, and voluntarily agree to the terms of this informed consent.

Signature of client _____Date _____

Signature of parent if client is under the age of 18 _____