Kristin Taravella, CMT #24250
645 Tamalpais Drive, Suite D, Corte Madera, CA 94925
(415) 225-2016

CLIENT INFORMATION:

Last Name: _____ First Name: _____ _____
Address: _____City/State/Zip_____
Date of Birth: _____Preferred phone number: (_____) _____-_____
E-mail Address: _____
How do you prefer to be contacted? (please circle) TEXT EMAIL PHONE
Employer: _____
Occupation: _____
Work Phone #: (_____)_____-_____ Family Physician:_____
Emergency Contact: _____Relationship to you:_____
Emergency Contact Phone:_____
How did you hear about us? _____
Reason for seeking treatment:_____

Have you ever had: **(please circle all that apply)** Skin problems or allergies to lotions/oils ☐Lymphatic problems/surgery☐ wear dentures or other appliances ☐ Wear contact lenses ☐ Phlebitis or history of phlebitis ☐ Blood clots or history or blood clots ☐ Heart problems ☐High Blood Pressure Spinal problems ☐ Thyroid Problems ☐ AIDS/HIV ☐ Hepatitis ☐ Diverticulitis ☐ Cancer ☐ Arthritis ☐Stroke ☐ Tumors/Growths ☐ Ulcers ☐ Anemia ☐ Blood Thinner ☐ Asthma ☐ Herniated Disc ☐ Hernia ☐ Joint Replacement ☐ Depression/Anxiety ☐ Allergies ☐ Prostate Problems

Other(s)? _____

Are you pregnant or is there a chance you are pregnant? YES NO

Surgeries/Hospitalizations Injuries/Fractures/Dislocations

Procedure and year: _____ _____
Procedure and year: _____ _____
Procedure and year: _____ _____

Have you suffered acute injury recently?

What & when? _____

Are you currently exercising regularly?

Yes; What kind and how oftern?_____
No; last regular exercise? _____
Has your condition prevented you from doing exercise? ☐ Yes ☐ No

Do you have any other medical condition I should be aware of before administering a Fasciablaster treatment on you?

What & when? _____

I am in general good health. I do not have a history or blood clots or deep vein thrombosis. I am not taking any blood thinners. I have stated all my known medical conditions and take it upon myself to keep Kristin Taravella updated on any changes in the status of my health during the course of treatments._____(initial)

I agree to communicate with Kristin Taravella regarding the amount of pressure used during the treatment and will request more or less pressure as needed. _____ (initial

I acknowledge and understand that use of the Fasciablaster may cause any or all of the following: **pain, swelling, edema, redness, stiffness, soreness** and **bruising,** all of which can range from minor to severe in some cases. Additionally, hormonal shifts, menstrual period changes, detox symptoms and/or aesthetic changes (such as cellulite appearing 'worse' before better, loose or crepey skin), may also occur. I also realize that like any other form of therapy, Fasciablaster treatments could potentially ***worsen*** my condition or cause the problems listed in the section above. I understand all of this and wish to receive Fasciablaster treatments anyway. _____(initial)

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek . _____(initial)

X_____
Signature/Date

Please mark areas of concern for you