First & Last Name: Gender (please specify):

Address: DOB: / /

Suburb/City: Post Code:

Phone: Mobile:

Email: Occupation:

Relationship status: Children:

EMERGENCY CONTACT DETAILS

Name:

Phone: Relationship to you:

Doctor / GP contact details: Name:

MEDICAL / GENERAL HEALTH HISTORY (ALL MODALITIES)

This section relates to your general health history, current symptoms, prescribed medications, allergies and other health conditions. The reason we ask these questions is to provide us with all relevant information that could affect you during your treatment which you are consenting to attend. In the case of a medical emergency, this information may also be very relevant to your professional medical care. It is not compulsory to provide this information but if you choose to provide it, it will assist us, and any attending doctor or other medical specialist, to support you.

General health history (eg list any major physical/emotional/mental incidents, allergies, disease or illness and when they occurred):

Current symptoms/ill conditions:

Are you pregnant?

☐ No ☐ Yes

Do you have Hepatitis A, B or C, HIV/AIDS or any other infectious disease?

☐ No ☐ Yes -- If yes:

Prescribed Medication & Supplements (list all prescribed medication and supplements you are currently taking):

Are you currently taking or do you ever take:

☐ Warfarin ☐ Diuretics (of any sort) ☐ Blood pressure medication

MODALITIES I CONSENT TO: **Please tick all that are applicable*

I consent to receiving treatment in the following modalities:

☐ Esoteric Healing / Esoteric Body Work (incl massage)
☐ Esoteric Chakra-puncture
☐ Esoteric Connective Tissue Therapy
☐ Esoteric Yoga

SEE OVER PAGE

WHAT I UNDERSTAND ABOUT THE TREATMENT: **Please tick the box if you agree and cross out any that do not apply*

☐ By signing this form, I indicate that I understand and accept the following:

- Esoteric Healing, Esoteric Body Work and Esoteric Connective Tissue Therapy are gentle hands on techniques that may involve massage (touch) directly on the skin.
- Esoteric Chakra-puncture is a gentle needling technique that pierces the skin to a depth of only 0.2-0.4mm using very fine needles, and is not acupuncture.

WHAT I UNDERSTAND ABOUT MY TREATMENT: **Please tick the box if you agree and cross out any that do not apply*

☐ By signing this form, I indicate that I understand and accept the following:

- I can ask questions at any time about the treatment provided.
- Practitioners at this clinic are not qualified to and nor do they give a medical diagnosis and no modality or service provided at this clinic offers a cure or alternative to medical treatment.
- I understand and accept that I must consult with a registered medical practitioner in the case of any illness or disease or if symptoms persist.
- The Universal Medicine Therapies are based on The Ageless Wisdom, are complementary-to-medicine, and have not been tested in CONSORT2010-compliant randomised controlled trials.
- I may withdraw consent for treatment at any time in writing to this clinic.
- I accept full responsibility for receiving the treatment(s) I have agreed on with my practitioner(s).

MY CURRENT CONDITIONS: **Please tick the box if you agree and cross out any that do not apply*

☐ Should I have any current illness or injury, however minor, I understand that it is my responsibility to make this known to my practitioner prior to attending the session, and to receive medical attention.

☐ I understand and agree that my attendance at each session is at my own risk and the practitioners take no responsibility for any injury or loss of any description suffered by me or anyone else as a direct or indirect consequence of my attendance at or participation in any session with the practitioner(s) named on this form.

MY CONSENT: **Please tick the box if you agree and cross out any that do not apply*

☐ By signing this form, I consent to my personal and health information, including my history, being:

- processed for the purposes of my treatment, administration and management of the practice, including in my home state and other countries, as needed;
- discussed with other practitioners including, without limitation, my GP, in order to review the quality of care provided to me;
- described in a written or verbal referral to any practitioner, should my practitioner feel that such referral is in my best interests, after having first discussed such referral with me;

☐ I consent to my personal and health information, including my history, being discussed anonymously with other practitioners for the purpose of research and development of the services and modalities provided at this clinic including, without limitation, their integrative qualities with conventional medicine, for the benefit of men and women generally.

MY CONSENT FOR TREATMENTS: **Please tick the box if you agree and cross out any that do not apply*

☐ By signing this form:

- I consent to the initial and ongoing consultations with the practitioner(s) I have booked in to see.
- I have read, understood and agree to all aspects of this consent form (except where crossed out and initialed by me) and I consent to treatments with my nominated practitioner and other practitioners at this clinic as agreed by me on the terms as outlined in this form.
- I agree that this consent form will remain active for future visits and other forms of consultation or advice at this clinic unless I otherwise notify this clinic in writing.
- I acknowledge and agree that this clinic and each practitioner at this clinic jointly and severally reserve the right to decline any booking (including mine) for attendance at any session, now or later, or to ask any client (including me) to leave any session at any time, for any reason they see fit.

I certify that the information I have provided above is accurate and complete to the best of my knowledge and, where I have disclosed information in relation to my medical conditions and current medications, that disclosure is complete and accurate.

Signed: Date:

Please indicate if signing as a Parent or Guardian[1]: ☐ Parent ☐ Guardian

Signature of interpreter (if required): Date:

[1] Please note: If you are signing as a Parent, Guardian or Interpreter then, by signing this form, you understand that you are indicating that you have fully informed the person you are caring or interpreting for about all the information outlined in this consent form.

PRACTITIONER TRADING NAME & ADDRESS[2]: