Client Intake Form - Minors

Personal Information

Child's Name _____

Your Name _____ Phone (M / H / W) _____

Email _____ Date of Birth _____

Address _____ City/State/Zip _____

Primary Physician _____

How did you hear about me? _____

Medical Information

Is your child taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Please indicate any of the following that apply to your child:

- ☐ Allergies/Sensitivities
- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Chronic Pain
- ☐ Orthopedic Injuries
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains
- ☐ Pregnant
- ☐ Other

Explain any condition you have marked above:

_____

_____

_____

_____

Please list any treatments your child is currently undergoing for health conditions, including alternative modalities like acupuncture, chiropractic, etc

_____

_____

Please list any major life traumas (injuries, hospitalizations, loss of a loved one, etc) and approximate age:

_____

_____

_____

Session Information

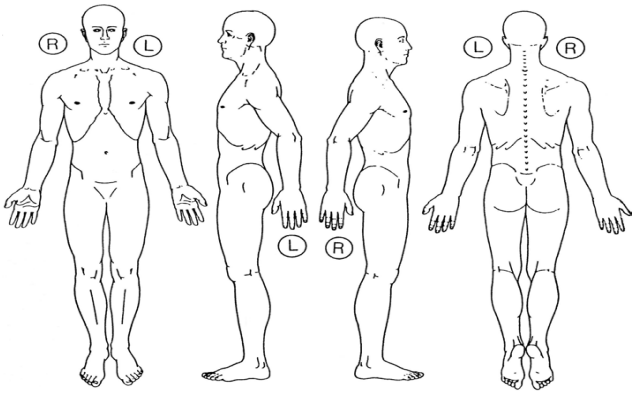
What are your goals for treatment, and major challenges you'd like to overcome? _____

_____

_____

_____

Please circle any areas of physical discomfort



What factors do you think may be contributing to your child's health challenges? (Injury, diet, lifestyle, family history, stress, relationships, illness, etc)

_____

_____

_____

_____

_____

By signing below, you agree to the following:

I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

_____

Parent/Guardian Signature

Date _____

Informed Consent and Liability Waiver for Minors

I understand that all massage/bodywork/energy healing techniques utilized by Kristian Googe and Vitality Wellness by Kris, LLC ("Vitality Wellness") are provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow. These techniques support the body's natural ability to heal by promoting harmony and balance within. Detailed descriptions of all services offered are available at www.yourpathtovitality.com

Any Distance Healing sessions my child may receive are completed via Zoom or via Email, and a copy of all session notes will be sent to me afterward. In either case, I understand the therapist will make a temporary connection to my child through a higher energetic source to identify any imbalances which need to be cleared. Any and all connections made are intended for my child's highest truth and good, and great care is taken in this process. The therapist may act as proxy on my child's behalf or may send energy healing through a proxy doll. The temporary connection will be automatically closed at the end of the session. I am encouraged to ask questions about this process or anything else that comes up during my sessions.

The therapist will check in with my child to ensure the level of pressure used is within their comfort level. My child and I are encouraged to speak up if they seem uncomfortable. I will not hold the therapist responsible for any pain or discomfort experienced during or after the session. All modalities/techniques, including medical massage, are performed over the clothes.

I understand that any services offered during sessions are not a substitute for medical care. The therapist is not a doctor and is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness. No claims are made as to healing or recovery from any current illness, nor the prevention of any future illness. No guarantee is made towards validity. Any suggestions made regarding supplementation or home programs of any kind should not be considered as prescriptions. I may follow these suggestions as I see fit, with the recommendation that I seek the advice of my child's primary doctor. I understand that my child's client information and records are treated in a confidential manner, compliant with HIPAA. I have the right to discontinue services, change consent, or leave at any time.

I affirm that I have notified the therapist of all known medical conditions and injuries. I agree to inform the therapist of any changes in health and medical condition. I understand that there shall be no liability on the therapist's part should I fail to do so.

While most energy healing methods are gentle, there may be risks. In approximately 20% of sessions, "processing" may occur as the energy body adjusts to any shifts. Temporary symptoms may include irritability, fatigue, headaches, or sleep disturbances. This "processing" appears to be a normal part of regaining energetic balance and typically lasts no more than 48 hours. Staying hydrated may ease these symptoms if they occur.

I understand that all necessary precautions are being taken, including sanitation and disinfecting practices recommended by the CDC and WHO, to ensure everyone's health and safety, and to limit the spread of communicable diseases such as Flu, Covid-19, etc. I agree to reschedule any in-office appointment, or switch it to a distance healing session, if any of the following statements apply to myself or my child in the 15 days leading up to any appointment scheduled: exhibiting symptoms or have exhibited symptoms; knowingly been exposed; or received a positive diagnosis which has not been followed by a negative test result. I agree to inform my therapist of any exposure risks I become aware of following any appointment so necessary steps can be taken to reduce the possible spread to other clients. I understand my therapist will inform me of any exposure risks that may arise so I can make the best decisions for myself and my family.

Except in the case of gross negligence or malpractice, I and my representatives (spouse, heirs, executors, administrators, legal representative, etc) agree to fully release and hold harmless Kristian Googe and Vitality Wellness for and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with these sessions, including but not limited to the unintentional exposure to or harm from COVID-19 or other infectious diseases.

A parent/legal guardian must provide informed written consent for any client age 17 or younger, and accompany their child during the entire session.

X _____ X _____

Minor Client Name (Print) Name of Parent or Legal Guardian

X _____ X _____

Parent/Legal Guardian Signature Date