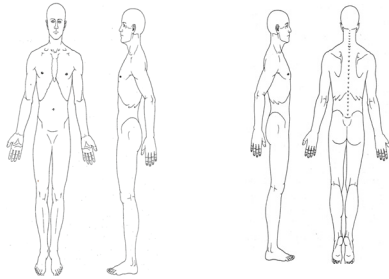


Complementary Alternative Medicine Asia

Name: _____ Date of Birth : _____ Gender: M / F
Contact: _____ E mail: _____
Address: _____
Physical Activity: _____
Referred By: _____ Internet: _____
Chief complaint: _____
Current Problem duration: Increasing / Decreasing / Constant / Night / Day / Morning / Stiffness / Intermittent
Duration: _____ Intensity : _____ Effects: _____
Aggravate by: _____ Relieve by: _____
Other symptoms: _____ Liftsytyle Habits _____
Treatment History: _____
Medication / Supplement: _____
History: _____
Musculoskeletal Examination: _____



Goal _____
Natural Solutions: _____

Therapeutic Session: _____

Informed Consent

By signing this form, I acknowledged that complementary alternative medicine therapy should not be construed as a substitute for medical advice, diagnosis, treatment or professional care. I have obtained clearance from my registered medical doctor which complementary alternative medicine therapy are appropriate. I acknowledged that Complementary alternative medicine therapy may involve physical examination, joint mobilization and/or soft tissues palpation. I am aware that I may experience some discomfort during and after afterwards through the use of complementary alternative medicine therapy. I have the rights to decline treatment at any time. The therapist has explained the results and discuss the recommended interventions with me.

WAIVER AND RELEASE: I hereby release, discharge and acquit Complementary Alternative Medicine Asia , it 's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Technician, physician or urgent care services. **TREATMENT OF MINORS:** I, as parent/guardian of a minor receiving therapy here under, do hereby agree and understand that I have been advised to remain on the premises during any such therapy, and waive any claim I may have resulting from failure to do so. **LIABILITY:** I know and agree that Complementary Alternative Medicine Asia is not responsible for loss or damage to personal valuables. I hereby consent to receive complementary alternative medicine therapy as deemed appropriate by the therapist.

I certify that all of the information provided herein is true and correct.

Sign: _____ Date: _____