CONSENT TO TREATMENT

I understand that shiatsu should not be construed as a substitute for medical examination, diagnosis, or treatment, and that it is recommended that I see a physician for any physical ailment that I may have. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile during the sessions.

I understand that shiatsu involves pressure applied to various parts of the body and is used to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches and the possible aggravation of symptoms existing prior to treatment. If I experience any pain or discomfort during the session, I will immediately inform therapist Jill Chapman so that the pressure may be adjusted to my level of comfort. I understand that I may stop the treatment if it is uncomfortable to me.

I have carefully read and understand all of the above information and by signing below, voluntarily consent to be treated with acupressure shiatsu by Certified Asian Bodywork Therapist, Jill Chapman at Good Life Acupuncture & Holistic Therapies.

Signature: _____ Date: _____

Printed Name: _____