Pathways to Health Client Information Form

Name:_____ Phone:_____cell

Address:_____ Phone:_____home

City:_____ ST:___ Zip:_____ Phone:_____work

Email:_____ Date of Birth: _____

Can we correspond to the above address? (Please note that we do not share this information.) __Yes __No

Profession:_____

In case of emergency, we should notify:

Name: _____ Relationship to you: _____Phone:_____

Referred by: _____

Reason for Visit:

Please describe why you are seeking treatment, symptoms, and what you hope to gain.

Health History: Please check all that apply and describe below.

Pain

__Neck Pain
__Back Pain
__TMJ Pain
__Headaches/Migraines
__Stiff Joints
__Whiplash
__Disc Problems
__Other Pain
__Muscle Spasms
__Inflamation
__Fibromyalgia
__Sciatica
__Tendonitis
__Scoliosis

Other Conditions

__High/Low Blood Pressure
__Heart Attack
__Stroke
__Chronic Symptoms/Conditions
__Chronic Fatigue Syndrome
__Digestive Problems
__Other Heart/Circulatory Conditions
__Flu/Cold
__Blood Clots
__Varicose Veins
__Edema
__Diabetes
__Cancer
__Epilepsy/Seizures
__Swelling
__Arthritis
__Osteoporosis
__Fever
__Addictions
__Skin Disorder
__Emotional Changes

Pathways to Health Client Information Form

Sleep

Describe the quality of your sleep and sleeping difficulties.

Accident History

Please describe significant accidents and injuries, including when they happened, how you were affected and remaining symptoms.

Surgeries

Dental History

Braces, Dentures, Bite Guards or other treatments.

Medications

Please list medications you are currently taking including the reason for taking them.

Pathways to Health Client Information Form

Other Treatments

What else have you done for your current condition/reason for visit (other types of health care, movement/exercise)?

Support & Resources

What type of support do you have in your life, and how do you resource yourself (i.e., where or to what do you turn in times of stress)?

What works well for you in life? (This can be anything, i.e., hobbies, relationships, jobs, there is no limit.)

I have completed this form to the best of my knowledge. I will continue to update this form and my therapist as my health and situation changes. By signing below, I hereby voluntarily consent to be treated with massage and/or craniosacral therapy from a licensed massage therapist. Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless Marcus Walther from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s). I understand that the massage therapist practicing in the state of Virginia is not a primary care provider and that regular primary care by a licensed physician is an important choice that is strongly recommended by us.

Signature_____ Date _____

Pathways to Health, L.L.C.

Consent to Treatment Form and Client Agreement

Practitioner: Marcus Walther, LMT, BCTMB
| Licensed Massage Therapist | Board Certified in Therapeutic Massage & Bodywork |
| Craniosacral Therapist | Energy Medicine Practitioner | Licensed Minister |

Status and Scope of Practice
I am a Licensed Massage Therapist in the Commonwealth of Virginia, Board Certified in Therapeutic Massage and Bodywork (NCBTMB) since 2006, a Craniosacral Therapist, Energy Medicine Practitioner, and Licensed Minister. I offer therapeutic massage, craniosacral therapy, energy balancing, and spiritual coaching services.

I provide services for both adults and children. For all pediatric sessions, parental or guardian consent and presence are required. Please note: while the child receives the session, the parent or guardian is considered the client of record.

These services are intended to promote relaxation, ease physical and emotional tension, and support overall well-being. I am not a physician, chiropractor, or mental health provider and do not diagnose, prescribe, or treat medical conditions. Clients are encouraged to maintain regular care with a licensed healthcare provider. Massage is not a substitute for medical diagnosis or treatment.

Description of Services
Massage Therapy
Massage therapy involves the manual manipulation of soft tissues to ease muscular tension, promote relaxation, improve circulation, and support emotional well-being. Sessions may incorporate a variety of techniques including, but not limited to: Swedish Massage, Deep Tissue Massage, Myofascial Release, Reflexology, Craniosacral Therapy, Trigger Point Therapy, assisted stretching, and other recognized massage methods as appropriate to client needs.

Craniosacral Therapy
A gentle, hands-on modality that focuses on the craniosacral system — the membranes and fluids surrounding the brain and spinal cord. The goal is to reduce restrictions, ease tension, and support balance in the central nervous system. This therapy is typically performed with the client fully clothed, but may be any comfort level of clothing with proper draping.

Energy Balancing
Energy Balancing is a non-invasive modality involving the evaluation and manipulation of the human energy field. Using the client's or practitioner's energy field, this work is intended to effect change in the client's energy field to help support their overall mental, emotional, physical, or spiritual health. Energy Balancing is a complementary service and is not intended to replace professional medical care.

Spiritual Coaching
As a Licensed Minister, I may offer spiritual coaching for clients seeking emotional, life-purpose, or spiritual guidance. Spiritual coaching is designed to complement — not replace — other therapeutic or medical services.

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Benefits & Risks
Potential benefits of these services include stress reduction, relief from muscular tension, improved circulation, enhanced flexibility, support for emotional balance, and activation of the body's self-healing mechanisms. Risks are minimal but may include temporary soreness, emotional release, fatigue or lightheadedness. Clients are encouraged to communicate openly and stop the session at any time if discomfort arises. Clients are responsible for informing the practitioner of any health conditions, medications, or changes before each session.

Education, Credentials, & Experience
- Licensed Massage Therapist (Virginia)
- Board Certified in Therapeutic Massage & Bodywork (NCBTMB) since 2006
- Trained in Craniosacral Therapy
- Licensed Minister
- Specialized training in Energy Balancing, Reflexology, and additional therapeutic techniques.

Further details on my background and ongoing professional education can be found on my LinkedIn profile.

Confidentiality
All personal and health information shared during treatment is confidential and will only be disclosed with written permission or as required by law.

Client Rights
You have the right to ask questions, modify or withdraw consent at any time, and expect professional, respectful conduct in all interactions.

Fees & Payment
Payment is due at the time of service unless prior arrangements have been made. Missed appointments or cancellations with less than 24 hours' notice will be charged the full session fee, except in the case of emergencies or extenuating circumstances, at the discretion of the practitioner.

Client Consent
I have read and fully understand the information above. I have had the opportunity to ask questions, and I consent to receive therapeutic massage, craniosacral therapy, energy balancing, and/or spiritual coaching services from Marcus Walther at Pathways to Health, L.L.C. I understand that no specific outcome has been promised or guaranteed. Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless Marcus Walther and Pathways To Health, L.L.C. from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).

Client Name (Printed): _____ Date: _____
Client Signature: _____
Address: _____
City/State: _____ Phone: _____
Practitioner Signature: _____ Date: _____

Consent to Treat Minor (if applicable)
I hereby authorize practitioners at Pathways to Health, L.L.C. to provide massage, craniosacral therapy, energy balancing, spiritual coaching, or other therapeutic services to my child or dependent.

Child's Name: _____ DOB: _____
Parent/Guardian Signature: _____ Date: _____
Printed Name of Parent/Guardian: _____