Third Space Wellness, LLC

CONSENT TO SERVICES

I, _____, understand that TSW Services (as defined below) are provided by Third Space Wellness, LLC ("TSW") staff and/or affiliated practitioners ("Clinicians"). I understand that this agreement covers the Clinician or Provider who initially treats me and any other Clinicians or Providers associated with TSW who may provide my treatment in the future.

I hereby give my consent to receive the following TSW Service:

Massage Therapy/Bodywork

I understand that the massage/bodywork I may receive is for the purpose of relaxation and relief of muscular tension, and is not intended as physical therapy. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment, and that the Clinicians are not qualified to perform spinal or skeletal adjustments.

Potential Risks: I understand that I may experience some pain or discomfort from massage/bodywork received. If during the massage/bodywork I experience such pain or discomfort, I will immediately inform the Clinician.

Medical Treatment: Our Clinicians are not a substitute for a medical doctor and will not suggest that I discontinue medical treatment. I understand that if I am currently under a physician's care, I should continue as long as my physician and I deem it necessary. It is my responsibility to consult with my physician before altering any prescribed medications or treatments. I understand also that if there is an emergency, or a worsening of my health condition, or if a new condition arises, that I should consult a licensed physician.

Voluntary: I hereby request and consent to receive TSW Massage Services. I have not been guaranteed any specific outcomes concerning the uses and effects of any TSW Service. I understand that I am free to discontinue any TSW Service at any time. I voluntarily assume all risks inherent in the nature of each of the TSW Services. I waive all claims, costs, liabilities, expenses and judgments against TSW and release TSW and its members, officers, agents, representatives, and employees from all claims, costs, liabilities, expenses, and judgments arising out of the TSW Service.

In-home visits: I understand that Third Space Wellness is not responsible for "slip and fall" circumstances when providing in-home services, and thus I am responsible for "slip and fall" circumstances that occur during an in-home visit.

By voluntarily signing below, I confirm that I have read, or have had read to me, and understand the above Consent to Services, have been told about and understand the risks of each of the TSW Service, and have had an opportunity to ask questions and have received satisfactory explanations. I understand that I can request more information at any time if desired. I understand that I have the right to refuse or discontinue any service any time and that this refusal may affect the expected results I am seeking. I intend this consent form to

cover the entire course of treatment for my present condition and/or my current wellness goals, as well as for any future condition(s) and/or goals for which I seek these services.

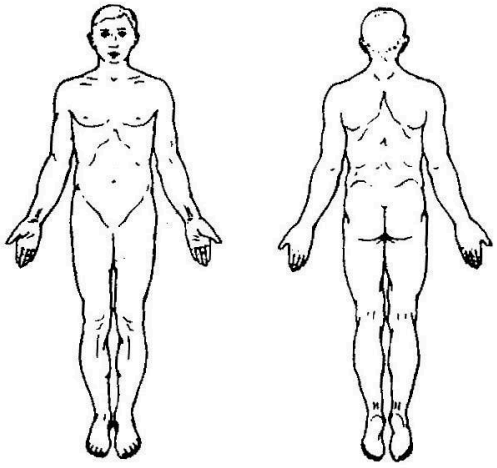
PLEASE PRINT:

Print Patient Name	Patient Birth Date
Street Address	City, State and Zip Code
Email Address	Preferred Phone Number
Emergency Contact Name	Emergency Contact Phone Number
Signature (or parent or guardian signature if client is a minor)	Today's Date

☐ Please exclude me from your mailing list.
We do not sell our mailing list.

Third Space Wellness, LLC

LIMITED HEALTH HISTORY



Please circle/mark where are you feeling pain, tension, numbness or tingling.

Describe what you are experiencing:

_____

_____

Are you currently pregnant?

☐ NO or N/A
☐ YES, how far along? _____ weeks

Medications & Supplements	***Please use the back of this sheet if you need more room.***
Are you currently taking any blood thinners, pain killers or muscle relaxers?	☐ NO ☐ YES, list them here:
Are you currently taking prescription drugs?	☐ NO ☐ YES, list them here:
Are you currently taking over-the-counter drugs, supplements, vitamins or herbs?	☐ NO ☐ YES, list them here:

Do you have a history of any of the following? Check all that apply:

☐ Hemophilia	☐ Diabetes	☐ Fainting
☐ Low Blood Pressure	☐ High Blood Pressure	☐ Seizures
☐ Heart Attack or Stroke	☐ Headaches or Migraines	

Please list any other history, injuries or surgeries in the past 5 years: _____

_____

Are there any other concerns you wish to discuss or feel your massage therapist should know?

☐ NO
☐ YES, list them here: _____

Circle level of massage pressure you prefer (10 is most): 1 2 3 4 5 6 7 8 9 10

Third Space Wellness, LLC
8001 Kennett Street, Suite B, Silver Spring, MD 20910
301.328.5326 | info@thirdspacewellness.com