Circle Yoga

Confidential Health Intake Form

Date _____

Name _____ Date of Birth _____

Street Address _____

City_____ State_____ Zip_____

Daytime Phone _____ Evening phone _____

Other Phone _____

Email _____

Emergency Contact Name _____

Emergency Contact Phone _____

Your Occupation _____

Referred By _____

Primary Care Physician _____

Reason for Seeking Massage Today _____

_____

_____

If injury, was Injury a result of an accident? yes or no (circle)

If "yes," was the accident: Job related ____ Auto ____ Other____

Date of Injury or onset: _____

I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

I agree to provide **24-hour** cancellation notice. If I fail to do so, I agree to pay the **full** appointment fee.

Bodywork Liability Waiver Agreement: I understand that massage at Circle Yoga Cooperative (CYC) includes physical touch and is not intended to diagnose, prevent, or cure any medical condition. As is the case with any therapeutic intervention, the risk of injury, even serious or disabling, is always present and cannot be entirely eliminated. I understand that it is my responsibility to consult with a physician prior to and regarding my bodywork. I represent and warrant that I am in good health and physical condition and that I have provided complete and accurate information on my medical intake form. In addition, I will make my bodyworker aware of any new medical conditions or physical limitations before my massage. I consent for my massage therapist to work within the scope of practice for therapeutic massage only, which is completely non-sexual in nature. If I am pregnant, become pregnant or I am post-natal or post-surgical, my signature below verifies that I have my physician's approval to receive massage.

In consideration of being permitted to receive massage at CYC, I agree to assume full responsibility for any risks, injuries or damages, known or unknown, which I might incur as a result of my participation. In further consideration of being permitted to receive massage at CYC, I expressly irrevocably release and waive any claims that I have now or may have hereafter for any reason against Circle Yoga Cooperative, its owners, employees and independent contractors, for injury or damages that I may sustain as a result of receiving massage at CYC.

Signature _____ Date _____

Circle Yoga Cooperative
Medical History and Information

Name _____ Date _____

Check any or all that apply to your present health:

___ headaches
___ vision problems
___ sinus problems
___ sprains/strains
___ fatigue
___ depression
___ sleep difficulties
___ pregnant
___ prostate problems
___ chronic pain
___ muscle or joint pain
___ numbness/tingling
___ diabetes
___ scoliosis
___ arthritis
___ tendonitis
___ painful menstruation
___ endometriosis
___ varicose veins
___ blood clots
___ high/low blood pressure
___ jaw pain/teeth grinding
___ cancer/tumors
___ infectious disease
___ skin problems

List all medications/herbs/vitamins you are currently taking. _____
_____
_____

List physical activities you participate in regularly. _____
_____

Describe the events of the injury or accident (if applicable) : _____
_____
_____

List any orthopaedic conditions or complications from childhood to the present. Include bone fractures, ligament sprains, chronic or acute muscular conditions, repetitive-use injuries, sports or high-impact injuries, surgical procedures, congenital conditions, and any other musculo-skeletal problem that affects your well-being. _____
_____
_____
_____
_____

Describe the areas of your body where you feel the most discomfort or pain. Indicate whether you experience dull or sharp sensations, numbness, or tingling, and how frequently.
_____
_____
_____

List previous major injuries/surgeries. _____
_____
_____

What other treatments are you receiving and by whom (acupuncture, physical therapy, chiropractic, naturopathic)? _____
_____
_____

What seems to help the most?_____

What seems to aggravate the condition the most? _____
_____

What is your main activity at work?
On phone _____ Sitting _____ Computer work _____ Driving car ____ Walking ____
Other _____

What do you do to relieve stress? _____
_____

Is there anything else you would like the therapist to know? _____
_____
_____