

# Circle Yoga

## Confidential Massage Intake Form

Date \_\_\_\_\_

Name \_\_\_\_\_ Preferred Name: \_\_\_\_\_ DOB \_\_\_\_\_

Preferred Pronouns She, Her / He, Him / They, Them / Other \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell \_\_\_\_\_ Home phone \_\_\_\_\_

Email \_\_\_\_\_ Your Occupation \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Emergency Contact Phone \_\_\_\_\_

Referred By \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Physician Phone \_\_\_\_\_

Reason(s) for seeking massage today \_\_\_\_\_

\_\_\_\_\_

If injury, date of injury: \_\_\_\_\_

Check any or all that apply to your present health:

- |                                             |                                               |                                                  |
|---------------------------------------------|-----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> headaches          | <input type="checkbox"/> chronic pain         | <input type="checkbox"/> high/low blood pressure |
| <input type="checkbox"/> vision problems    | <input type="checkbox"/> numbness/tingling    | <input type="checkbox"/> jaw pain/teeth grinding |
| <input type="checkbox"/> sinus problems     | <input type="checkbox"/> diabetes             | <input type="checkbox"/> cancer/tumors           |
| <input type="checkbox"/> sprains/strains    | <input type="checkbox"/> tendonitis           | <input type="checkbox"/> infectious disease      |
| <input type="checkbox"/> fatigue            | <input type="checkbox"/> arthritis            | <input type="checkbox"/> skin problems           |
| <input type="checkbox"/> depression         | <input type="checkbox"/> painful menstruation |                                                  |
| <input type="checkbox"/> anxiety            | <input type="checkbox"/> endometriosis        |                                                  |
| <input type="checkbox"/> sleep difficulties | <input type="checkbox"/> scoliosis            |                                                  |
| <input type="checkbox"/> pregnant           | <input type="checkbox"/> varicose veins       |                                                  |
| <input type="checkbox"/> prostate problems  | <input type="checkbox"/> blood clots          |                                                  |

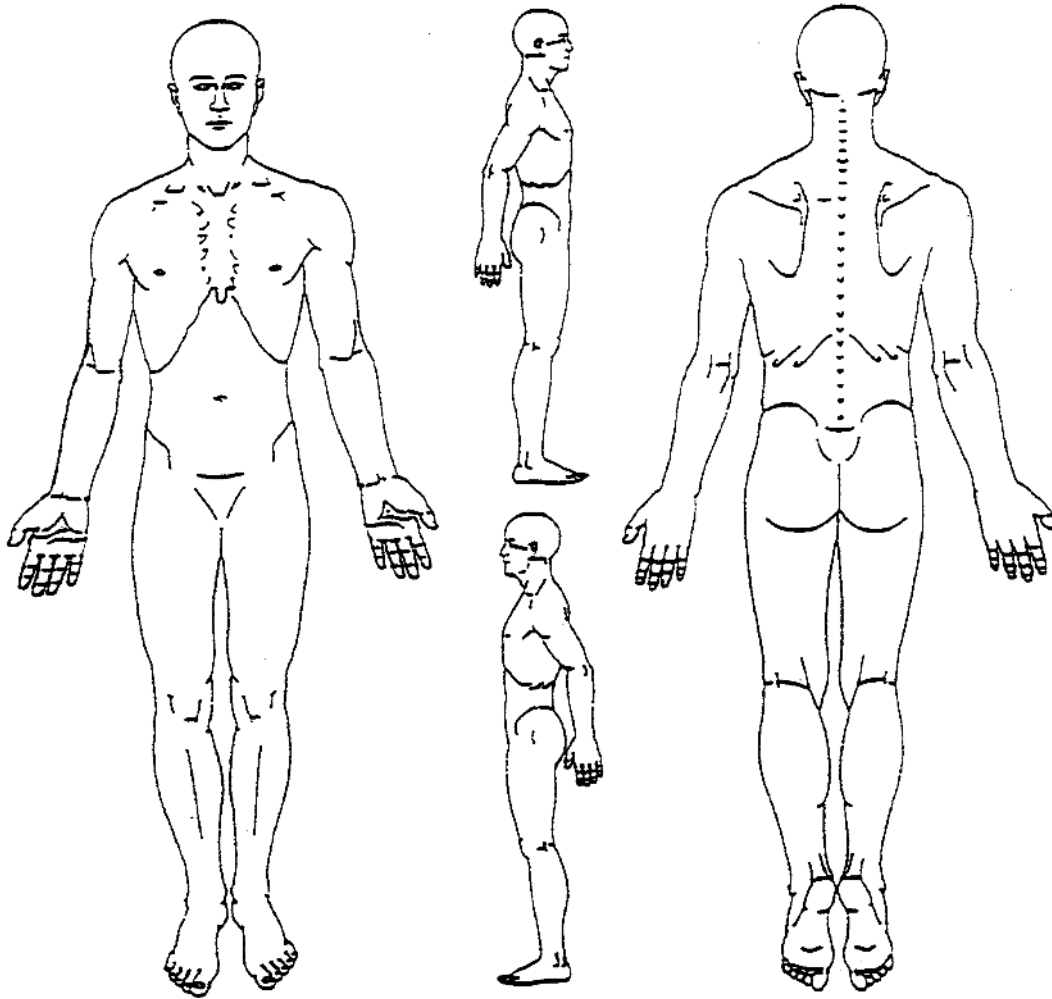
Other \_\_\_\_\_

Allergies \_\_\_\_\_

List all medications, herbal supplements, and vitamins you are currently taking \_\_\_\_\_

\_\_\_\_\_

Indicate areas of pain or discomfort below:



Indicate sensations in the areas circled such as dull or sharp, numbness, tingling, and how frequently

\_\_\_\_\_

What helps the most? \_\_\_\_\_

What seems to aggravate the condition? \_\_\_\_\_

List any other treatments you are receiving including acupuncture, chiropractic, physical therapy, etc.

\_\_\_\_\_

What physical activities do you participate in and how often? \_\_\_\_\_

List any prior (childhood to present) injuries, accidents, falls, surgeries, or congenital conditions

\_\_\_\_\_

Is there anything else you would like your therapist to know? \_\_\_\_\_

\_\_\_\_\_

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. 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 addition, I will inform my bodyworker of any new medical conditions or physical limitations prior to each session.

I consent for my massage therapist to work within the scope of practice for therapeutic massage only, which is completely non-sexual in nature.

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 \_\_\_\_\_

Signature of Parent or Guardian (if under 18) \_\_\_\_\_ Date \_\_\_\_\_