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:

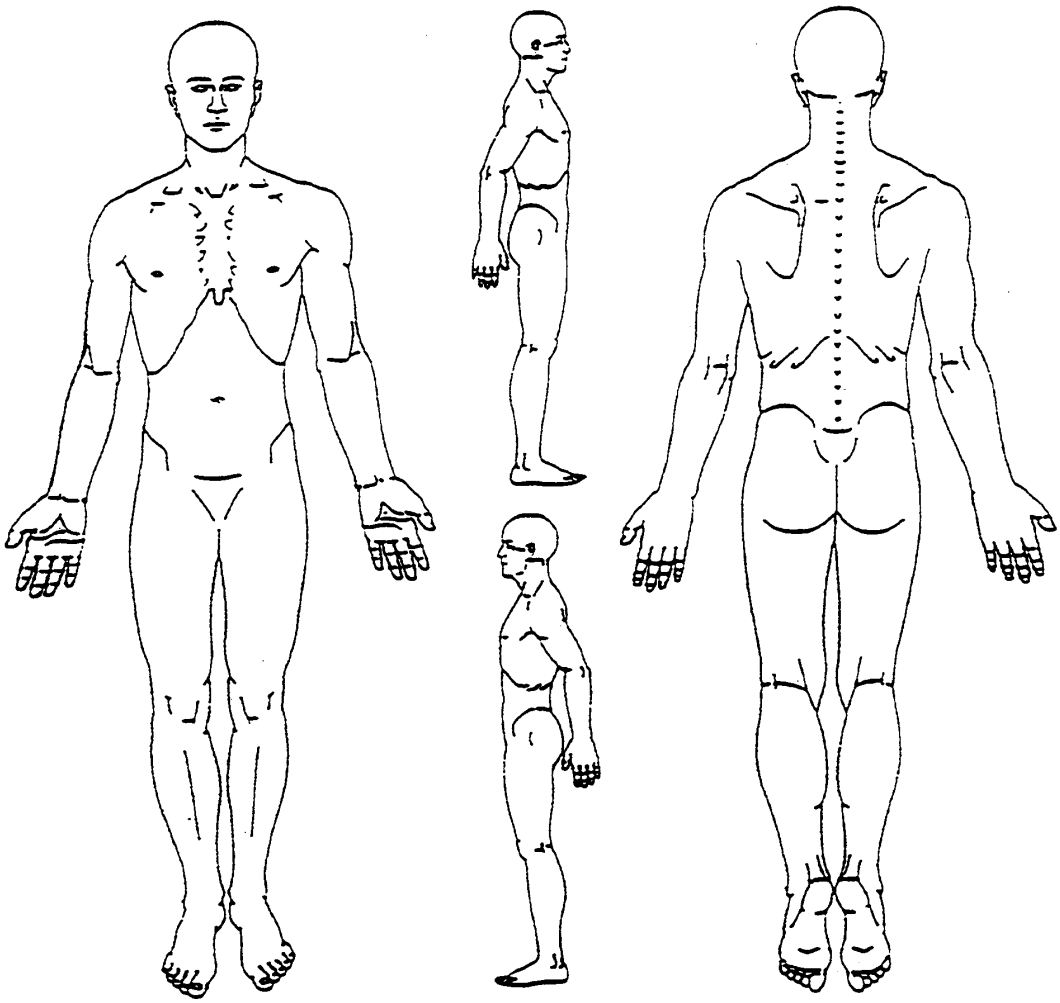
___ headaches
___ vision problems
___ sinus problems
___ sprains/strains
___ fatigue
___ depression
___ anxiety
___ sleep difficulties
___ pregnant
___ prostate problems
___ chronic pain
___ numbness/tingling
___ diabetes
___ tendonitis
___ arthritis
___ painful menstruation
___ endometriosis
___ scoliosis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

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, sugeries, 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 inorm 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_____