



HEALING METHODS

Therapeutic Yoga & Massage

Client Information

Name: _____ DOB: _____

Address: _____ City/State/Zip: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

How did you hear about us: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

Reason for today's visit?

Have you ever had a professional massage before? Yes ___ No ___

Are you pregnant? Yes ___ No ___

PLEASE MARK IF YOU HAVE/HAD ANY OF THE FOLLOWING CONDITIONS:

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vascular/Blood Disorders |
| <input type="checkbox"/> Skin Disorders | <input type="checkbox"/> Immune Disorders | <input type="checkbox"/> Stomach Disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Respiratory Disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Back or Chest Aches |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck/Shoulder Pain |
| <input type="checkbox"/> Sciatic Pain | <input type="checkbox"/> Leg/Foot Pain | <input type="checkbox"/> TMJ Syndrome |
| <input type="checkbox"/> Neuropathies | <input type="checkbox"/> Edema | <input type="checkbox"/> Breast/Augmentation |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Wear Contacts | <input type="checkbox"/> Herniated/Building/Degenerative Disc |
- Allergies to oils/ scent _____
- Chemotherapy/ Radiation Treatment When? How Long? _____

Do you Smoke? _____ Drink Alcohol? _____ Drink Caffeine? _____
Drink Soda? _____ Eat Chocolate? _____ Use lots of salt? _____
Exercise/ Stretching Habits? _____
How many times per week? _____ Duration? _____
Please advise us of any other health care professionals you have seen for this
condition _____

Do you take any prescription medication? _____ If yes, please list:

Do you have any **other** medical issues including past surgeries or injuries that I should be aware of before giving you massage therapy? If yes, please describe:

Please read the following, initial and sign below:

___ Be aware that our Licensed Massage Therapists have wide variety of Advanced Training. Techniques to be used include Myofascial Release, Trigger Point, Swedish gymnastics, Visceral manipulation, Manual Lymphatic drainage, Craniosacral, Cupping, Muscle Energy Techniques, Range of Motion, Stretching, KinesioTaping.

___ Body parts to be treated include face, neck, scalp, shoulders, arms, hands, back, buttocks, hip flexors, legs, and feet. Therapists may treat muscles of the chest and ribcage; however they do *not* engage in massage of breast tissue.

___ Our Massage Therapists utilize only conservative draping during our sessions. If I feel uncomfortable for any reason I may ask to end the session.

___ I understand that the Massage Therapist does not diagnose illness, disease, or any other physical or mental disorder, nor perform spinal adjustments. Massage therapy is not a substitute for medical examinations and/or diagnosis. It is recommended that I see a physician for any physical ailment that I might have. I understand that Massage Therapy given here is for the purpose of, but not limited to: Fulfilling a prescription of a treating physician for a medically necessary condition. For relief from muscular spasm or fascial tension. To improve circulation.

___ Because a Massage Therapist must be aware of existing physical conditions; I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

___ I will respect the time of my Massage Therapist(s) and other clients. I agree to come to my scheduled appointments promptly, barring any unforeseen emergency. I understand that if I cancel later than 4 hours prior to my appointment, I agree to pay HALF the cost of my appointment. If I NO SHOW, I agree to pay the FULL price of the appointment.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____