YOGA INFORMED CONSENT FORM

FIRST:______________________ MIDDLE:___________ LAST:_______________________ BIRTHDATE:_______/_______/_______

_____ FEMALE _____ MALE PHONE:_______________________________ PHONE:_______________________________

STREET:____ CITY:_______________________

STATE:__________ ZIP:__________ EMAIL:____

EMERGENCY CONTACT:____ PHONE:_________________________

HOW DID YOU HEAR ABOUT US? REFERRED BY?____

OCCUPATION:___________________________________ HOBBIES:____

HOW WOULD YOU RATE YOUR OVERALL HEALTH? ___EXCELLENT ___VERY GOOD ___GOOD ___FAIR ___POOR

HAVE YOU HAD PREVIOUS MASSAGE? ___NO ___YES - RESULTS: ___EXCELLENT ___GOOD ___FAIR ___POOR

WHAT IS YOUR GOAL/CONCERN FOR TODAY'S SESSION?____

HERE IS A LIST OF THINGS MASSAGE CAN HELP WITH. PLEASE CIRCLE THE ONES THAT APPLY TO YOU:

REDUCE STRESS AND ANXIETY REDUCE MUSCLE SORENESS AND TENSION

IMPROVE CIRCULATION IMPROVE IMMUNE FUNCTION IMPROVE MOOD

REDUCE PAIN SLEEP BETTER IMPROVE FLEXIBILITY AND RANGE OF MOTION

LOWER HEART RATE AND BLOOD PRESSURE INCREASE RELAXATION

WHAT KIND OF PRESSURE DO YOU PREFER? ___LIGHT ___MEDIUM ___FIRM

ARE YOU SENSITIVE TO TOUCH OR PRESSURE IN ANY AREA? ___NO ___YES: ________________________________

DO YOU EXPERIENCE ANY DIFFICULTY LYING EITHER ON YOUR FRONT OR YOUR BACK? ___YES FRONT ___YES BACK

ARE THERE CERTAIN STANDING OR SITTING POSITIONS YOU NEED TO AVOID OR THAT ARE PAINFUL OR UNCOMFORTABLE? ____NO ____YES: ____

HAVE YOU LOST THE ABILITY TO DO SOMETHING YOU WOULD LIKE TO REGAIN? ____NO ____YES:

____

IS THERE ANY AREA WHERE YOU SEEM TO HOLD A LOT OF TENSION?____

HAVE YOU EVER BEEN HOSPITALIZED? ___NO ___YES: ____

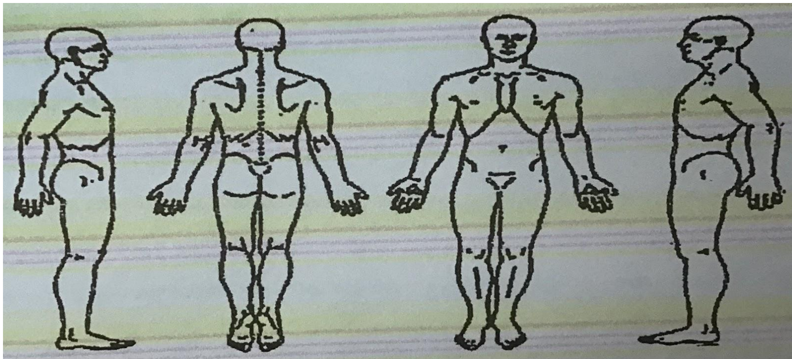
HAVE YOU HAD SIGNIFICANT FRACTURES, FALLS, AUTO ACCIDENTS, ETC.? ___NO ___YES: ________________________

ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITIONS? ___NO ___YES: ____________________________

LIST ALL PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING AND FOR WHAT CONDITION:

____

INDICATE ON THE DRAWINGS BELOW WHERE YOU HAVE PAIN/SYMPTOMS.



USING A SALE FROM 1-10 (10 BEING THE WORST), HOW WOULD YOU RATE YOUR PROBLEM?

0 1 2 3 4 5 6 7 8 9 10

IF YOU HAVE PAIN(S), HOW OFTEN DO YOU EXPERIENCE YOUR PAIN SYMPTOMS?

___CONSTANTLY (76-100% OF THE TIME) ___FREQUENTLY (51-75% OF THE TIME)

___OCCASIONALLY (26-50% OF THE TIME) ___INTERMITTENTLY (1-25% OF THE TIME)

HOW WOULD YOU DESCRIBE THE TYPE OF PAIN? ____

___SHOOTING ___NUMB ___DULL ___TINGLY ___SHARP WITH MOTION

___ACHY ___STIFF ___DIFFUSE ___SHARP ___BURNING

___STIFF ___STABBING WITH MOTION ___SHOOTING WITH MOTION ___ELECTRIC LIKE WITH MOTION

HOW ARE YOUR SYMPTOMS? ___GETTING WORSE ___STAYING THE SAME ___GETTING BETTER

DOES PAIN INTERFERE WORK? __NOT AT ALL __A LITTLE BIT __MODERATELY __QUITE A BIT __EXTREMELY

DOES PAIN INTERFERE WITH ACTIVITIES? __NO ___LITTLE BIT ___MODERATELY ___QUITE __EXTREMELY

DO YOU CONSIDER THIS PROBLEM TO BE SEVERE? __YES __YES, AT TIMES __NO

HOW LONG HAVE YOU HAD THIS PROBLEM?____

HOW DO YOU THINK YOUR PROBLEM BEGAN?____

WHAT AGGRAVATES YOUR PROBLEM?____

WHAT HELPS YOUR PROBLEM?____

	YES PAST	NOW	NO		YES PAST	NOW	NO
Pregnancy	___	___	___	Anemia	___	___	___
Headaches	___	___	___	Raynaud's	___	___	___
Neck Pain	___	___	___	Easy Bruising	___	___	___
Whiplash	___	___	___	Angina	___	___	___
Upper Back Pain	___	___	___	Kidney Stones	___	___	___
Mid Back Pain	___	___	___	Kidney Disorders	___	___	___
Low Back Pain	___	___	___	Bladder Infection	___	___	___
Herniated Disc	___	___	___	Painful Urination	___	___	___
Shoulder Pain	___	___	___	Loss of Bladder	___	___	___
Elbow/Upper Arm Pain	___	___	___	Frequent Urination	___	___	___
Wrist Pain	___	___	___	Abdominal Pain	___	___	___
Hand Pain	___	___	___	Irritable Bowel Syndrome	___	___	___
Hip Pain	___	___	___	Abdnormal Weight Gain	___	___	___
Upper Leg pain	___	___	___	Abdnormal Weight Loss	___	___	___
Knee Pain	___	___	___	Loss of Appetite	___	___	___
Ankle/Foot Pain	___	___	___	Crohn's	___	___	___
Jaw Pain	___	___	___	Hernia	___	___	___
Whiplash	___	___	___	Ulcer	___	___	___
Joint Pain/Stiffness	___	___	___	Hepatitis	___	___	___
Arthritis	___	___	___	Liver/Gall Bladder Disorder	___	___	___
ALS	___	___	___	General Fatigue	___	___	___
Parkinson's	___	___	___	High Stress/Anxiety	___	___	___
Multiple Sclerosis	___	___	___	Panic Attacks	___	___	___
Neuritis/Neuralgia	___	___	___	Fibromyalgia	___	___	___
Fibrositis	___	___	___	Hypothyroidism	___	___	___
Rheumatoid Arthritis	___	___	___	Hyperthyroidism	___	___	___
Cancer	___	___	___	Endocrine Disorders	___	___	___
Auto Immune Disease	___	___	___	Muscular Incoordination	___	___	___
Osteoporosis	___	___	___	Visual Disturbances	___	___	___
Orthopedic Pins/Plates	___	___	___	Dizziness	___	___	___
Tumor, Cysts, Lipomas	___	___	___	Diabetes	___	___	___
Asthma/Breathing Problems	___	___	___	Excessive Thirst	___	___	___
Pneumonia	___	___	___	Poor Sleep / Insomnia	___	___	___
Chronic Sinusitis	___	___	___	Tinnitis, Ear Ringing	___	___	___
Heart Problems	___	___	___	Prostte Problems	___	___	___
High Blood Pressure	___	___	___	Smoking / Tobacco Use	___	___	___
Low Blood Pressure	___	___	___	Drug / Alcohol Dependence	___	___	___
Heart Attack	___	___	___	Allergies	___	___	___
Chest Pains	___	___	___	Depression	___	___	___
Stroke	___	___	___	Grieving	___	___	___
Peripheral Artery Disease	___	___	___	Systemic Lupus	___	___	___
Blood Clots, Phleboliths	___	___	___	Epilepsy	___	___	___
Hemophilia	___	___	___	Dermatitis/Eczema/Rash	___	___	___
Varicose/Spider Veins	___	___	___	HIV/AIDS	___	___	___
Bad Circulation	___	___	___	Rash	___	___	___
Gout	___	___	___	Osteoarthritis	___	___	___
Pregnant	___	___	___	Other Conditions:	___	___	___

PLEASE READ AND INITIAL BEFORE EACH STATEMENT.

___CANCELLATIONS/RESCHEDULES MUST BE MADE NO LESS THAN 24 HOURS OR WILL BE FULLY CHARGED.

___IF LATE, THE SESSION WILL END AT THE APPOINTED TIME.

___YOGA INCLUDES PHYSICAL MOVEMENTS AS WELL AS AN OPPORTUNITY FOR RELAXATION, STRESS RE-EDUCATION, AND RELIEF OF MUSCULAR TENSION. AS IN THE CASE WITH ANY PHYSICAL ACTIVITY, THE RISK OF INJURY, EVEN SERIOUS OR DISABLING, IS ALWAYS PRESENT AND CANNOT BE ENTIRELY ELIMINATED. IF I EXPERIENCE ANY PAIN OR DISCOMFORT, I WILL LISTEN TO MY BODY, ADJUST THE POSTURE AND ASK FOR SUPPORT FROM THE TEACHER. I WILL CONTINUE TO BREATHE SMOOTHLY.

___YOGA IS NOT A SUBSTITUTE FOR MEDICAL ATTENTION, EXAMINATION, DIAGNOSIS OR TREATMENT. YOGA IS NOT RECOMMENDED AND IS NOT SAFE UNDER CERTAIN MEDICAL CONDITIONS. I AFFIRM THAT I ALONE AM RESPONSIBLE TO DECIDE WHETHER TO PRACTICE YOGA.

___I WILL BE 100% RESPONSIBLE FOR ANY COST INCURRED FOR MEDICAL ATTENTION AS A RESULT OF MY PARTICIPATION IN YOGA CLASS, TAKING FULL RESPONSIBILITY FOR OVER-EXERTION, ACCIDENTS, AND ALL INCIDENTS.

______________________________   ______________________

CLIENT SIGNATURE   DATE

CONSENT TO TREATMENT OF MINOR: I HEREBY AUTHORIZE MASSAGE AND BODYWORK TECHNIQUES TO MY CHILD.

______________________________   ______________________

SIGNATURE OF PARENT OR GUARDIAN   DATE