

## GENERAL INTAKE

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you pregnant?  Yes  No If yes, what trimester? \_\_\_\_\_ Current athletic ability:  Poor  Average  Good

Do you have any allergies (especially to nuts)?  No  Yes (specify) \_\_\_\_\_

What is your chief complaint or reason(s) for this visit? \_\_\_\_\_

What worsens the condition? \_\_\_\_\_

Are you currently seeing a doctor for any reason?  No  Yes (explain) \_\_\_\_\_

Which service(s) have you experienced?  Massage  Acupuncture  Yoga  Reiki  Other \_\_\_\_\_

Regarding massage, what type of pressure/techniques would you anticipate? \_\_\_\_\_

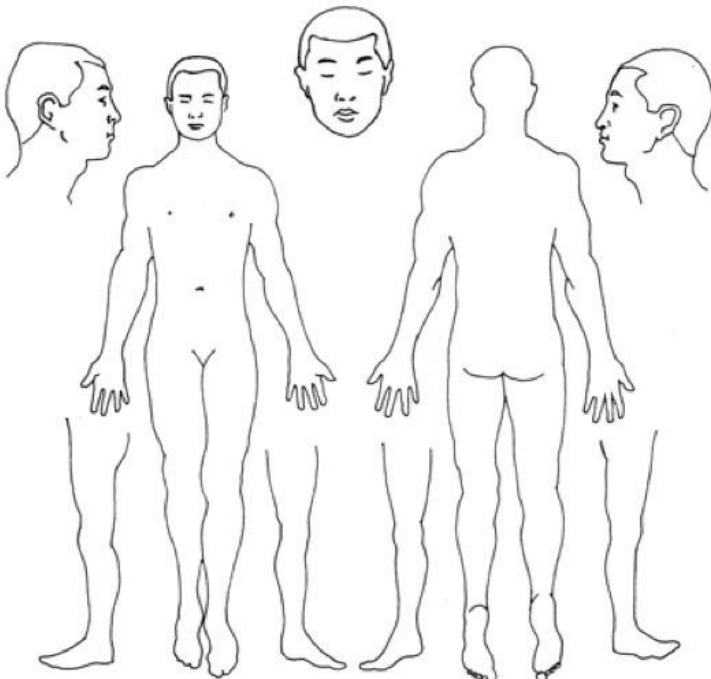
Have you been involved in an accident, had surgery, or been hospitalized in the last 3 years?  Yes  No

List any chronic conditions that you deal with on a regular basis: \_\_\_\_\_

Are you taking any medications or herbs?  No  Yes (specify) \_\_\_\_\_

### MARK PAINFUL OR DISTRESSED AREAS

For massage: X = avoid areas, O = focus massage on these areas



### Review this list and check those conditions that apply to you.

- |   |  |
|---|--|
| <input type="checkbox"/> Hip Replacement      | <input type="checkbox"/> Currently in Chemotherapy   |
| <input type="checkbox"/> Pregnant             | <input type="checkbox"/> Rib fracture/bruise         |
| <input type="checkbox"/> Disc Herniation      | <input type="checkbox"/> Spinal Compression Fracture |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Neck Trauma/Pain            |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Open Wounds                 |
| <input type="checkbox"/> Current Fractures    | <input type="checkbox"/> Osteoporosis                |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Rash                        |
| <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Rotator Cuff Tear           |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Scoliosis                   |
| <input type="checkbox"/> Heart Condition      | <input type="checkbox"/> Shoulder Trauma             |
| <input type="checkbox"/> Hernia               | <input type="checkbox"/> Spinal Trauma               |
| <input type="checkbox"/> Knee Replacement     | <input type="checkbox"/> Stroke History              |
| <input type="checkbox"/> Low Back Trauma/Pain | <input type="checkbox"/> Vertigo                     |



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### Agreement of Release and Waiver of Liability *(please read and sign)*

I understand that canceled or missed appointments without 24-hour notice (medical emergencies excluded) may be charged in full for the price of missed session.

I understand the service(s) I am receiving may be contraindicated for specific medical conditions and symptoms. I further understand the services are not substitutes for medical care and that therapists for these services do not diagnose disease, prescribe medicine or manipulate bones. If at any time during the service I feel uncomfortable, I may end the session. I take responsibility for alerting my therapist or instructor to any changes that occur with my health.

I understand that draping of the breast will be used at all times for female clients during each session for massage and cupping, and therapists will not massage the breasts without written consent. I understand that draping of the genital area and gluteal cleavage will be used at all times for all clients during each session for massage and cupping.

Therapist will immediately end the session if a client initiates any verbal or physical contact that is sexual in nature.

For classes, workshops, private yoga & reiki: I agree that I am participating in sessions offered by Serasana during which I will receive information and instruction. Physical exertion is expected, which may be strenuous and may cause physical injury, and I am fully aware of the risks and hazards involved. I understand that it is my responsibility to consult with a physician prior to and regarding my participation. I represent and warrant that I am physically fit, and I have no medical condition which would prevent my full participation. In consideration of being permitted to participate, I agree to assume full responsibility for any risks, injuries, or damages, known or unknown, which I might incur as a result of participation.

I knowingly, voluntarily, and expressly waive any claim I may have against Serasana, its owners, teachers or therapists for injury or damages that I may sustain as a result of my participation. I, my heirs or legal representatives forever release, waive, discharge and covenant not to litigate Serasana, its owners or any of the other teachers for any injury or death caused by their negligence or other acts.

I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

**Client signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If under 17 years, signature of legal guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Therapist's signature (if applicable):** \_\_\_\_\_ **Date:** \_\_\_\_\_