

Robin Enochs

311 Forest Ave, Suite 6
Pacific Grove, CA. 93950

Integrative Massage and Yoga

ayoganut@gmail.com
312-933-5459

First and Last Name _____

Email Address _____ Cell Phone # _____

Street Address _____

City _____ State _____ Zip Code _____

Birth Date _____

Emergency contact _____ Phone # _____

Emergency contact relationship _____

Date of initial visit _____ Referred by _____

Have you had a professional massage before?

Yes (Date of last) _____

No

Types of massage/bodywork received _____

Preferred types of massage _____

Expected Outcome _____

How would you rate your general health?

Excellent

Good

Fair

Poor

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List current medications & the conditions being treating _____

List any major accidents or surgeries (including dates) _____

Please list any allergies or hypersensitivities _____

Reason for initial visit _____

HEAD NECK

Headaches / migraines

ringing in ears

Vision problems

Vertigo / dizziness

Hearing loss Vision loss

RESPIRATORY

Asthma

Chronic cough

Emphysema

Smoker

CARDIOVASCULAR

High blood pressure

Heart attack

Heart disease

Varicose veins

Chronic congestive heart failure

Low blood pressure Stroke

Poor circulation

Pacemaker

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OTHER CONDITIONS

Infectious skin conditions or Cellulitis

Diabetes

Undergoing Chemo or Radiation, If so please discuss with your massage therapist

Other _____

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis.

I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I hereby release, waive, covenant not to sue, discharge, and hold harmless Integrative Massage and Yoga, its agents, contracted therapists, and representatives.

I understand that I am solely responsible for payment of my sessions at time of service, I agree to a 24 hour cancelation policy for all scheduled treatments or payment in full.

Signature _____ Date _____