Temple Lomi Lomi
HAWAIIAN MASSAGE

MY THAI MASSAGE

HEALING WATER MASSAGE

Intake Form and Release of Liability Agreement

Yoga Plus Inc.
17617 Crown Valley Court
Apple Valley, CA 92307

Client Information

Name you want to be called by: _____

Legal Name as shown on your Identification

First: Middle: Last:

Home Address

Street Address (no PO boxes):		
City:	State:	Zip:

Contact Info	**Emergency Contact**
Cell Phone:	Name:
Work Phone	Relationship to
Home Phone:	Day phone:
	Night phone:

Email: _____

Referred by: _____

Height: _____ **Weight:** _____

The person named above is herein referred to as "CLIENT"

Yoga Plus Inc. of Apple Valley, California dba "Temple Lomi Lomi", and dba "My Thai Massage" and dba "Healing Water Massage" including its employees, directors, owners, officers, practitioners, agents, insurers, successors and assigns is herein referred to as "YP".

It is important for you to provide us with complete and accurate information to determine if massage activities are safe for you or to learn how to modify them to meet your needs to accommodate existing issues. The information requested is important for the safety of yourself and our staff, and health information is kept strictly confidential.

Are you currently under a physician's care and if so for what?

__ Yes __ No

_____

_____

_____

Medications – Please list all medications and pain relievers you are taking and the reason you are taking them:

_____

_____

_____

Please check each item that applies to you and provide additional explanation.

- ❑ Accidents or Injuries _____
- ❑ Arthritis _____
- ❑ Athletes foot _____
- ❑ Back problems _____
- ❑ Blood clots (embolism, thrombosis) _____
- ❑ Cancer (if yes please list type and current status) _____
- ❑ Cerebral palsy _____
- ❑ Circulatory problems _____
- ❑ Constipation _____
- ❑ Crohn's disease _____
- ❑ Diabetes _____
- ❑ Digestive Problems _____
- ❑ Disc Problems (herniated, bulging, fused) _____
- ❑ Dizziness _____
- ❑ Epilepsy or Seizures _____
- ❑ Fibromyalgia _____
- ❑ Headaches (tension headache, migraines) _____
- ❑ Heart disease _____
- ❑ Heart issues (angina, heart attack, congestive heart failure, murmur) _____
- ❑ Hernia _____
- ❑ High blood pressure _____
- ❑ Joint problem (list locations) _____
- ❑ Lupus _____
- ❑ Lymphedema _____
- ❑ Major illness or disease _____
- ❑ Neurological problems _____
- ❑ Osteoporosis _____
- ❑ Osteoarthritis _____
- ❑ Pacemaker _____
- ❑ Pregnant (if yes, how long) _____
- ❑ Recent breaks/sprains _____
- ❑ Respiratory problems _____
- ❑ Sinus problems _____
- ❑ Skin problems _____
- ❑ Spinal problems (spinal stenosis, scoliosis) _____
- ❑ Strokes _____
- ❑ Surgical pins or wire, Artificial joints/special equipment _____
- ❑ Swelling _____
- ❑ Tenderness _____
- ❑ Thyroid problem _____
- ❑ Vein Issues (varicose veins, spider veins, phlebitis) _____

Please list any other issues we should be aware of

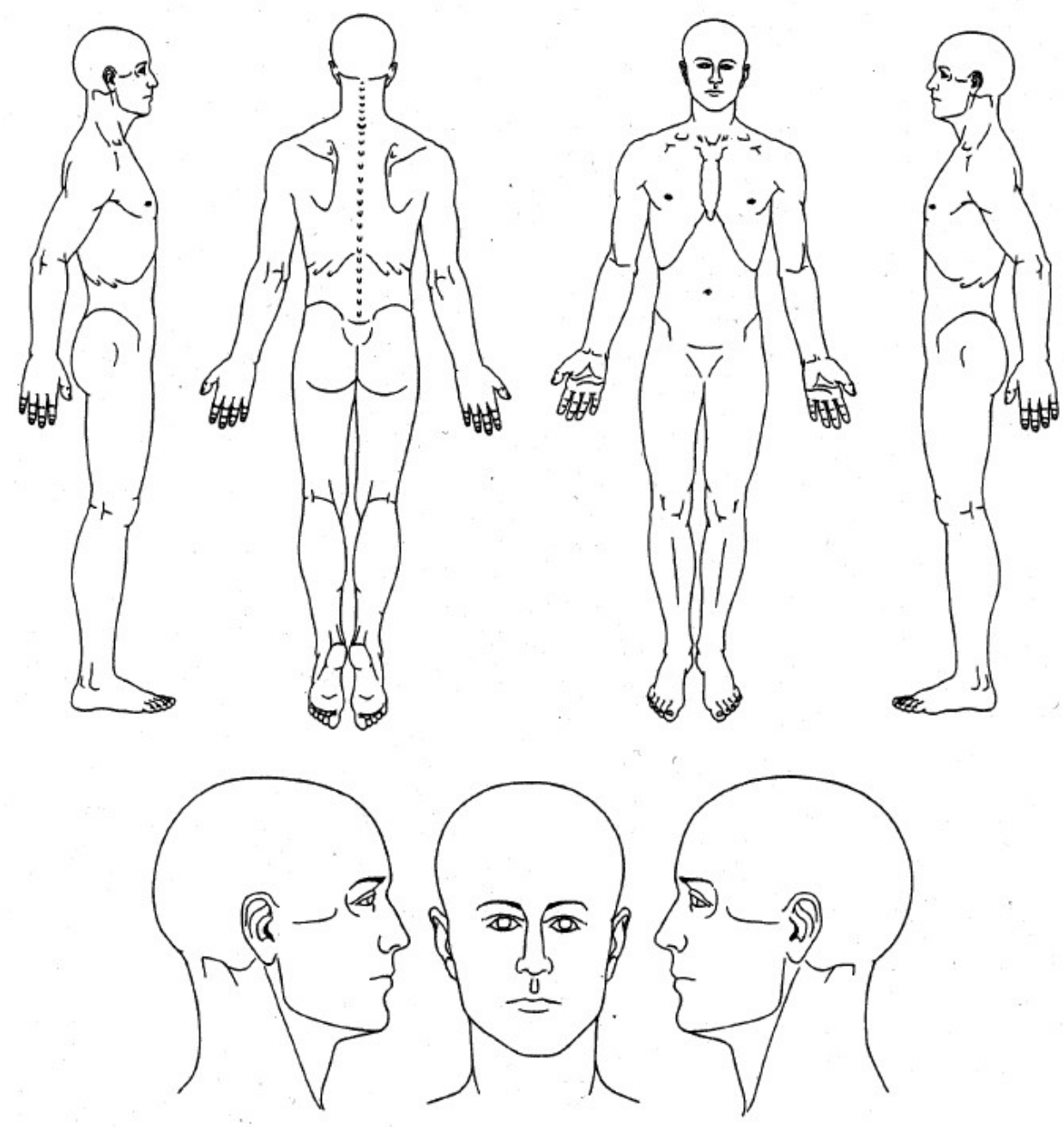
_____

_____

_____

_____

Mark areas (preferably in red) that you have had pain lately, try to be as precise as possible



COVID Waiver

I acknowledge the contagious nature of the Coronavirus (COVID-19) and that the CDC and many other public health authorities still recommend practicing social distancing.

YP has put in place preventative measures to reduce the spread of COVID-19.

I acknowledge that YP cannot guarantee that I will not become infected with COVID-19.

I understand that the risk of becoming exposed to and/or infected by COVID-19 may result from the actions, omissions, or negligence of myself and others.

I voluntarily seek services provided by YP and acknowledge that I am increasing my risk of exposure to COVID-19.

Please circle any of the following symptoms that you have currently

Chills	Fever	Muscle pain
Cough	Headache	Shortness of breath
Difficulty breathing	Loss of smell	Sore throat
	Loss of taste	

Have you been diagnosed with Coronavirus/Covid-19 ? __ Yes __ No

_____
_____
_____
_____

If you answered yes, please explain how you have been cleared as non-contagious

_____
_____
_____
_____

Have you been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19 __ Yes __ No

_____
_____
_____

Do you agree that as a condition of receiving service you will wear a non-vented mask when required? __ Yes __ No

In exchange for services, CLIENT agrees to the following provisions:

1. **Medical Conditions** – CLIENT affirms they have indicated all known medical conditions and injuries and that all information is correct and current.
2. **Doctor Approval** – CLIENT agrees to consult a primary health care practitioner regarding conditions of concern before receiving services.
3. **Notify of Pain** – If CLIENT experiences pain during any activity, CLIENT will immediately inform the therapist.
4. **Notify of Limits** – CLIENT will be responsible to inform therapist of any limitations in range of movement, or specific sensitivities.
5. **Notify of Changed Health** – CLIENT agrees to inform therapist of any changes in health or medical condition.
6. **Cancelling Appointments** – CLIENT may cancel or change an appointment with no charge any time up to 4 business hours before the appointment time. Otherwise, CLIENT will be charged 50% of the scheduled service.
7. **Inappropriate Behavior Not Tolerated** – Inappropriate behavior from clients or employees will not be tolerated. CLIENT and therapist both have the right to refuse or stop a service at any time for any reason.
8. **Accept Risks** – CLIENT understands and voluntarily accepts the risks associated with receiving massage. By signing this you state your understanding that massage may be useful in maintaining wellness, but it does not take the place of a doctor's care. Any information received during a session is educational and is intended to bring awareness to your own health situation and is to be used at your own discretion. You understand that the practitioner is not diagnosing or prescribing anything for your medical needs. You will always remain in full control and take full responsibility for your own wellbeing during a session. By signing this you agree to not hold the therapist or YP liable for any adverse effects of any treatment administered.

I hereby release and agree to hold YP harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of YP, or that may otherwise arise in any way in connection with any services received from YP. I understand that this release discharges YP from any liability or claim that I, my heirs, or any personal representatives may have against YP with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services or employment received from YP. This liability waiver and release extends to YP together with all owners, partners, and employees.

Dated: _____

Client Signature: _____

Name of Party Signing: _____

Lomi Lomi Questions

You only need to fill out this section if you are receiving Lomi Lomi

Do you have any nut allergies?

__ Yes __ No

_____

_____

Optional Chest Massage Release for Lomi Lomi

By signing this consent form, I am choosing to receive a massage without chest draping. The intention of removing the draping is so that I can receive massage on my sternum and intercostals. All breast tissue will be reasonably avoided, this will not be breast massage. I understand that the nipples and/or areolas of my breasts will not be touched during the massage. I understand that I can alter or rescind my consent at any time during this or any treatment and choose to wear chest draping.

Signature _____ Date: _____

Clinical Questions

You only need to fill out this section if you are receiving Clinical Bodywork

Are you currently under the care of an alternative medicine practitioner and if so for what?

__ Yes __ No

_____

_____

_____

Are you currently under the care of a chiropractor and if so for what?

__ Yes __ No

_____

_____

_____

List any vitamins, minerals, supplements that you take:

_____

_____

_____

Please list any recent injury, fracture, accident, medical or other health related items whether diagnosed by a medical professional, or self-assessed.

_____

_____

_____

Do you use any other body therapies?

___Chiropractic ___Massage ___Physical Therapy ___Acupuncture ___Tens Unit

Other: _____

What do/did you use the therapy for?

_____

_____

_____

How much water do you drink per day ? _____

List any food sensitivities:

_____

_____

_____

Do you wear orthotics and if so how long have you worn them?

__ Yes __ No

_____

_____

_____

Clinical Questions-continued

You only need to fill out this section if you are receiving Clinical Bodywork

Do you or did you as a child prefer to sit on one leg?

__ Yes __ No

Describe any pain/tension. How long have you had it?

_____
_____
_____

Was there an event or illness that seemed to start it?

_____
_____
_____

Is your pain/tension worse in the morning or evening?

_____
_____
_____

Does anything seem to change your pain? Make it worse/better?

_____
_____
_____

Are there particular movements associated with your pain?

_____
_____
_____

Please list any accidents, surgeries, etc. starting with the most recent.

Date/Accident

_____
_____
_____
_____
_____

Jaw/Facial Pain:

Do you have TMJ? ___Yes ___No
Do you have jaw pain associated with chewing or yawning? ___Yes ___No
Do you clench or grind your teeth? ___Yes ___No
Do you wear a night guard? ___Yes ___No
When was your last dental appointment? _____
Do you wear bifocals or progressive lenses? ___Yes ___No
Do you or have you ever experienced any visual disturbances? ___Yes ___No
If yes, please explain?_____
When was your last eye doctor appointment? _____

Clinical Questions-continued

You only need to fill out this section if you are receiving Clinical Bodywork

Life/General:

Rate the level of stress in your life as you perceive it:

___High ___Medium-High ___Medium ___Medium-Low ___Low

What are your goals regarding your overall quality of life?

1. _____
2. _____
3. _____
4. _____

Home Stress:

Do you have child-care or other home-tasks? ___Yes ___No

Are you immobile for long periods of time? ___Yes ___No

Do you lie on the couch or bed and read? ___Yes ___No

Work Stress:

Are you able to work? ___Yes ___No

_____

How do you feel after a day of work?

_____

Does your pain affect your work?

_____

What is your occupation?

_____

Do you perform repetitive movements at work?

_____

Are you immobile for long periods of time?

_____

Given the opportunity, what would you like to do?

_____

Activities/Hobbies:

List any activities/hobbies you do on a regular basis? (musical, sport, sewing, gardening, etc.) and how frequently you do them:

_____

_____

_____

Clinical Questions-continued

You only need to fill out this section if you are receiving Clinical Bodywork

Exercise:
Are you able to exercise? ___Yes ___No
What types of exercise do you do and how frequently?

_____
_____

What type of exercise do you think you would enjoy doing?

_____
_____

Do you stretch regularly? ___Yes ____No
If yes, what stretches, when? _____

Sleep:
How many hours of sleep do you typically get? _____
Do you experience any of the following?
___Difficulty Falling Asleep ___Waking Often ___Waking Unrefreshed
What position do you sleep in?
___Back ___Side ___Stomach ___Arms Overhead
___Half-Stomach/Half-Side ___Fetal Position ___Spooning ___With Pets
If you sleep on your back, do you put pillows under your knees? ___Yes ___No
If you sleep on your side, do you put pillows between your legs? ___Yes ___No
At your chest? ___Yes ___No

Alcohol/Tobacco/Caffeine/Sugar:
Do you drink alcohol? ___Yes ___No
What kind and how often?

_____
Do you smoke or use tobacco products? ___Yes ___No
What kind and how often?

_____
Do you drink caffeinated beverages? ___Yes ___No
What kind and how often?

_____
Do you drink juice? ___Yes ___No
What kind and how often?

_____
Do you frequently eat foods with high amounts of sugars/carbohydrates? ___Yes ___No
What kind and how often?

_____

If you have any other information you wish to provide please do so below:

_____
_____
_____