Temple Lomi Lomi
Intake Form and Release of Liability Agreement

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

Email: _____

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" 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?

_____
_____
_____

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

_____
_____
_____

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

_____
_____

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

- ❑ Athletes foot _____
- ❑ Blood clots (embolism, thrombosis) _____
- ❑ Cancer (if yes please list type and current status) _____
- ❑ Cerebral palsy _____
- ❑ Crohn's disease _____
- ❑ Diabetes _____
- ❑ Disk Problems _____
- ❑ Dizziness _____
- ❑ Epilepsy _____
- ❑ Fibromyalgia _____
- ❑ Headaches (tension headache, migraines) _____
- ❑ Heart disease _____
- ❑ Heart issues (Pacemaker angina, heart attack, congestive heart failure, murmur) _____
- ❑ Hernia _____
- ❑ High blood pressure _____
- ❑ Joint problem (list locations) _____
- ❑ Lupus _____
- ❑ Lymphedema _____
- ❑ Osteoporosis _____
- ❑ Pregnant (if yes, how long) _____
- ❑ Scoliosis _____
- ❑ Strokes _____
- ❑ Surgical pins or wire, Artificial joints/special equipment _____
- ❑ Swelling _____
- ❑ Tenderness _____
- ❑ Vein Issues (varicose veins, spider veins, phlebitis) _____

We may require you to obtain doctor approval if we feel it may be unsafe for you to begin or continue with an activity due to health related concerns.

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 remain in full control at all times 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.

Dated: _____

Client Signature (or Guardian's if under 18): _____

Name of Party Signing: _____

Chest Massage Release

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. As well, 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:_____