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**
Home Phone:	Name:
Work Phone	Relationship to
Cell 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

____

____

____

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

__ Yes __ No

____

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Are you currently under the care of a chiropractor 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:

List any medications you have used in the past and why you stopped taking it:

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

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

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__ 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? _________________________

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. ____

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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:

____
____
____

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

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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?

____

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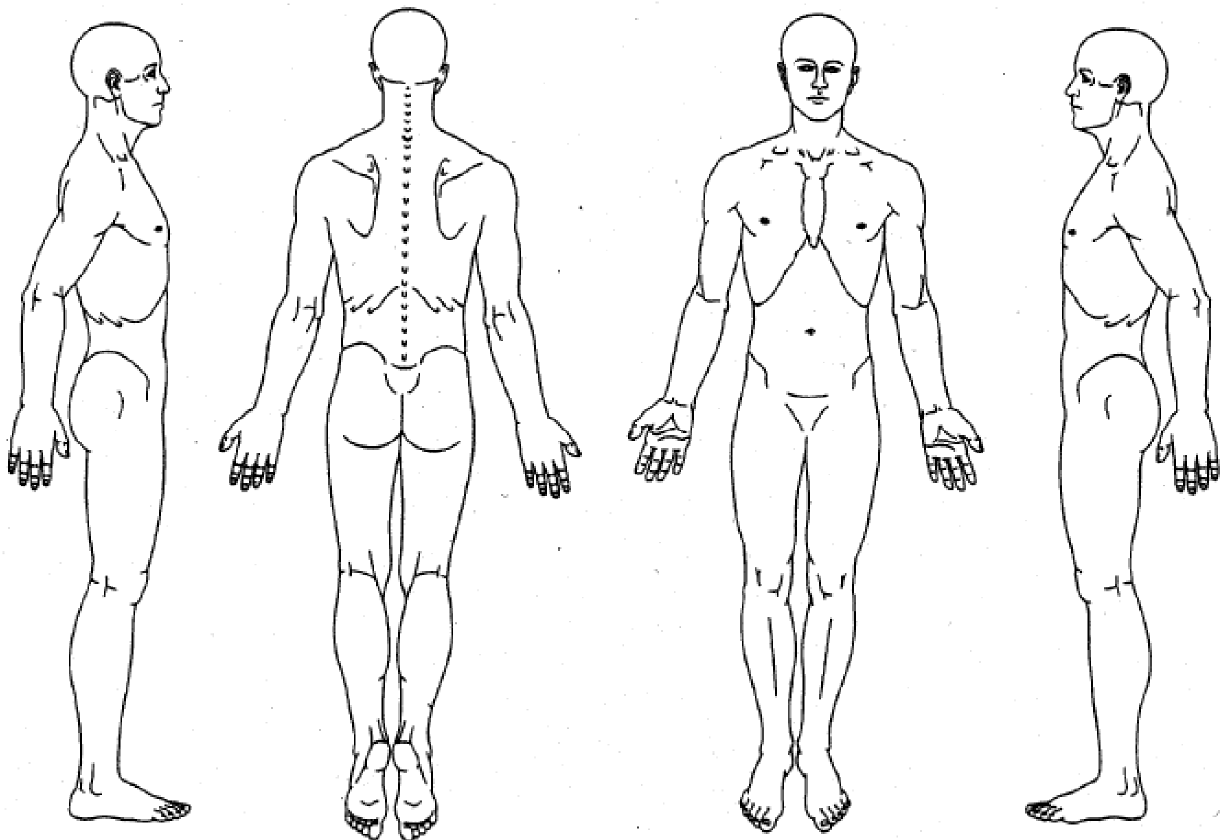
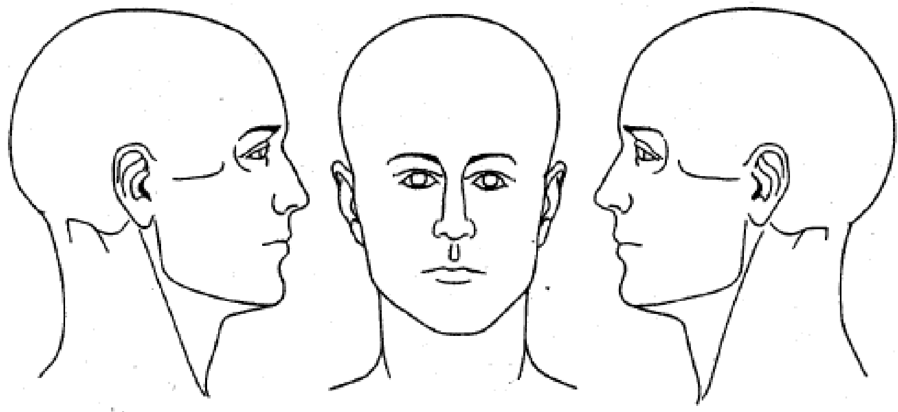
Mark areas (preferably in red) that you have had pain lately, try to be as precise as possible





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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) ______________________________

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.

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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.

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 the Coronavirus/COVID-19.

I acknowledge that YP cannot guarantee that I will not become infected with the Coronavirus/Covid-19.

I understand that the risk of becoming exposed to and/or infected by the Coronavirus/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 to exposure to the Coronavirus/COVID-19.

I attest that:

- ❑ I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
- ❑ I have not traveled internationally within the last 14 days.

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- [ ] I have not traveled to a highly impacted area within the United States of America in the last 14 days.
- [ ] I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
- [ ] I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non-contagious by state or local public health authorities.
- [ ] I am following all CDC recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.

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 (or Guardian's if under 18): ____

Name of Party Signing: ____

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. 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:______________

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