Robin Enochs
614 Lighthouse Ave. Unit G
Pacific Grove, CA. 93950

Integrative Massage and Yoga

312-933-5450
ayoganut@gmail.com

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______________________