

# Metta Bhau

## Thai Yoga Massage and Private Yoga Sessions Massage Consent & Liability Waiver Form

It is my choice to receive Thai Yoga Therapy and/or Private Yoga Sessions. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or balancing energy flow.

I understand that Yoga Teachers do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment. I acknowledge that Thai Yoga Therapy and Private Yoga Sessions are not substitutes for medical examinations or diagnosis. It is recommended that I see my primary health care provider for exams and diagnosis.

I have discussed with the therapist the nature and purpose of Thai Yoga and other related healing modalities. I understand that results will vary depending on the individual and the extent of their condition. It is the client's responsibility to notify the practitioner immediately if the client should feel their well-being is being compromised in any way.

**I have read the above and have had the opportunity to ask questions about the content.**

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# INTAKE FORM

## Personal Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Referred by \_\_\_\_\_

Date of Initial Visit \_\_\_\_\_ Height & Weight \_\_\_\_\_

Current Health \_\_\_\_\_

Reason for initial visit \_\_\_\_\_

Emergency Contact Name (relationship) \_\_\_\_\_

Do you exercise regularly and/or participate in any sports? Y N  
If yes, what kind of exercise/sports?

Do you perform any repetitive movement in your work, sports or hobby? Y N  
If yes, describe

Do you sit for long hours at a workstation, computer or driving? Y N  
If yes, describe

Do you experience stress in your work, family, or other aspect of your life? Y N  
If yes, describe

Are you experiencing tension, stiffness, discomfort or pain? Y N  
If yes, describe

Have you had a professional massage before? Y N  
If yes, what types of massage have you had (swedish, shiatsu, deep tissue, etc.)?

Do you have sensitive skin? Allergies to oils, lotions, ointment Y N

Have you recently had an injury, surgery, or areas of inflammation?                    Y     N

If yes, describe how long have you been receiving massage therapy? Frequency of massages?

What are your goals for treatment?

List any medications you are currently taking

List any known allergies

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**HEALTH HISTORY** (Please Circle)

**Musculoskeletal**

Bone or joint disease Tendonitis/Bursitis Arthritis/Gout

Jaw Pain (TMJ)

Spinal Problems Migraines/Headaches Osteoporosis

**Circulatory**

Heart Condition Phlebitis/Varicose Veins Blood Clots

High/Low Blood Pressure Lymphedema Thrombosis/Embolism

**Respiratory**

Breathing Difficulty/Asthma Emphysema

Allergies, specify:

Sinus Problems

**Nervous System**

Shingles Numbness/Tingling

Pinched Nerve/ Chronic Pain / Paralysis

Multiple Sclerosis

Parkinson's Disease

**Reproductive**

Pregnant? stage \_\_\_\_\_ Ovarian/Menstrual Problems Prostate

**Digestive**

Irritable Bowel Syndrome Bladder/Kidney Ailment Colitis

Crohn's Disease

Ulcers

**Psychological**

Anxiety/Stress Syndrome Depression

**Other**

Cancer/Tumors

Diabetes Drug/Alcohol/Tobacco Use Contact Lenses

Dentures Hearing Aids

**Allergies**, specify:

**Skin**

Rashes

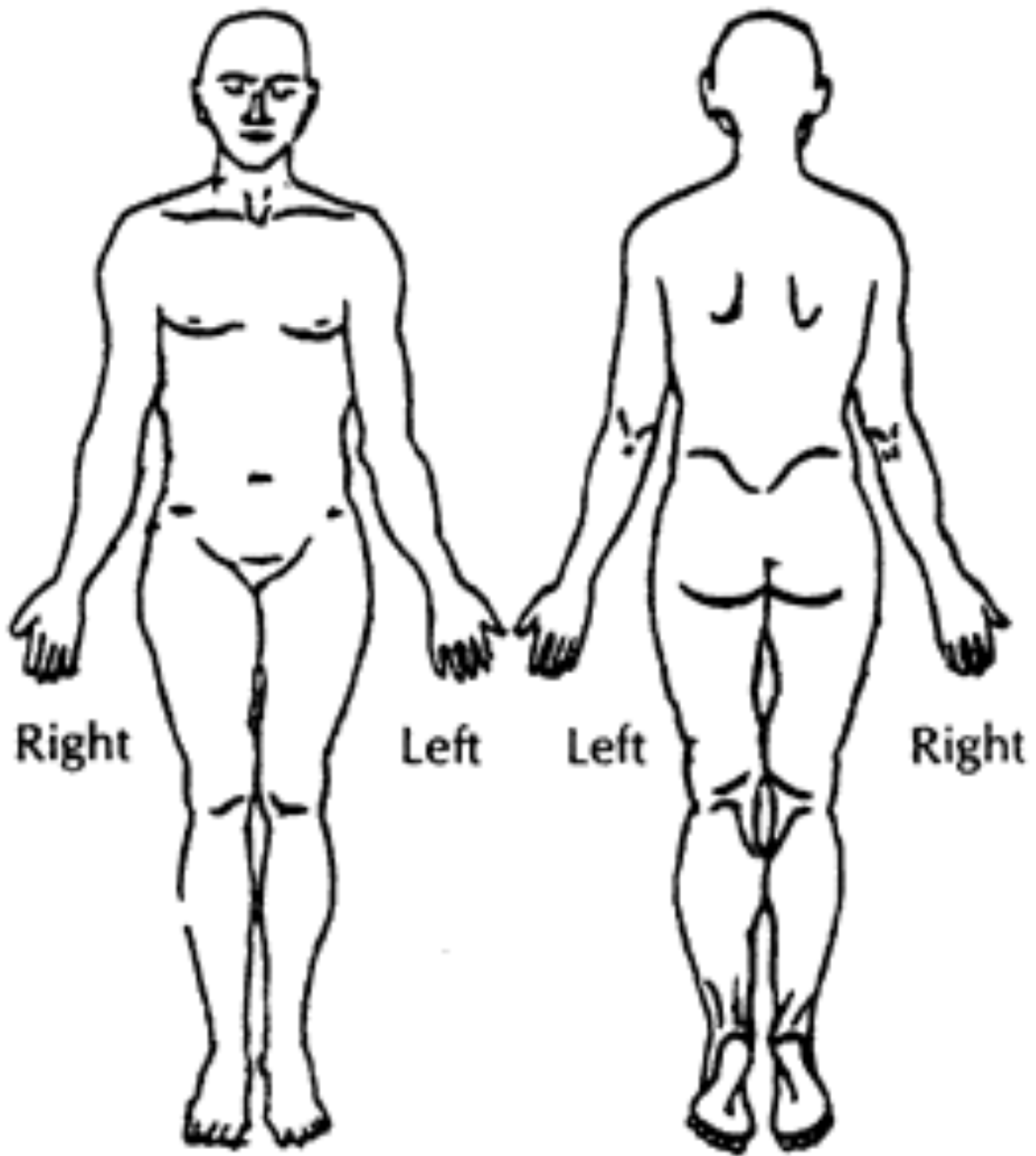
Athlete's Foot Herpes/Cold Sores

**Cosmetic Surgery**

Any other medical condition(s) not listed:

Please explain any of the conditions that you have marked above :

This form was created as a resource by the american massage therapy association® and they are not held liable for any services provided.



Please circle any point on the body that needs more attention. Please note any current or previous injuries/ chronic conditions.

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