CHANDI
YOGA & MASSAGE

Name _____Primary Phone_____

Address_____City/St/Zip_____

DOB _____ Occupation _____

Email _____

Emergency Contact _____Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ yes ☐ no
If yes, please list _____
Are you currently pregnant? ☐ yes ☐ no
If yes, how many weeks?_____ Risk factors? _____
Do you suffer from chronic pain? ☐ yes ☐ no
If yes, please explain _____
Have you had any surgeries? ☐ yes ☐ no
If yes, please list: _____

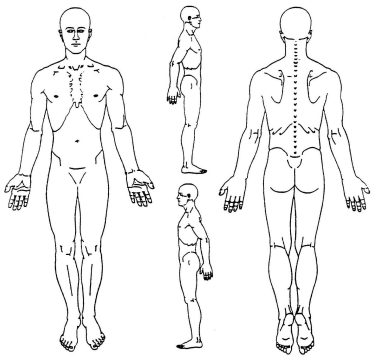
Please indicate any of the following that apply to you.

☐ Cancer
☐ Headaches/Migraines
☐ Arthritis
☐ Diabetes
☐ Blood Clots
☐ Fibromyalgia
☐ Stroke
☐ Heart Attack
☐ Kidney Dysfunction
☐ High/Low Blood Pressure
☐ Joint Replacement(s)
☐ Sprains or Strains
☐ Neuropathy
☐ Numbness

Massage Information

What type of massage are you seeking?
☐ Relaxation ☐ Therapeutic Other _____
What pressure do you prefer?
☐ Light ☐ Medium ☐ Deep
Do you have any allergies or sensitivities? ☐ yes ☐ no
Please explain _____

Indicate areas of discomfort:



I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ Date _____