Asanda Yoga & Massage Client Assessment Form

Client Name: _____ Date of 1st visit:_____

Date of Birthday: _____ Home number:_____

Cell: _____ E mail: _____

Emergency contact name: _____ Contact number: _____

Family Doctor: _____ Contact number:_____

Please list any medications (Herbal & other): _____

_____

Past surgeries: _____

Past Injuries: _____

Broken Bones: (Please list)_____

Location of any Internal pacemaker, pins, wires, artificial STS?: (Please list)_____

Are you undergoing any forms of treatment?_____

(Examples: Chiropractor, Physiotherapist,Chemotherapy)

(Details if yes)_____

Do you have any allergies to scents? _____

Any current skin conditions or rashes?_____

Please circle any past or current health problems:

Headaches	Menopause
Arthritis	Painful menstruation
Allergies	Bone or joint disease
Insomnia	Poor circulation
Cold hands/feet	Shoulder pain
Skin conditions	
Back pain	
(low, mid, upper)	Neck pain
Leg pain	Tendonitis
IBS	Constipation
Poor digestion	
Kidney/Bladder	

High blood pressure	Low blood pressure
Cancer	
Diabetes	
Heart attack	
Stroke	

What is your primary reason for your Hot Stone Massage today?

_____

_____

CONSENT TO TREATMENT

I _____, of my own free will and volition consent to to be treated for the following complaint (s): _____
_____
_____

I, _____acknowledge that my therapist, **Tania Wlotzki** has provided me with such information as is pertinent to the treatment of my complaint (s). Alternative courses of treatment have been explained to me as well as the possible risks and side effects of my therapist's proposed treatment plan.
I understand fully the consequences of having treatment/not having treatment. I understand that the information provided on this form will be confidential and will be used for no other purpose than the professional therapist's clinical records.

CLIENTS SIGNATURE:_____ DATE: _____