Health History and Release Form

Name:_______________________________________Phone #______:________________Work/Cell:_________________________
Address:_____________________________________City:_________________State:______________Zip:________________________
Date of Birth:_____________________Email:____
Emergency Contact:____________________________Relationship:_________________Phone:___________________________
Have you ever had a professional Pilates/Massage/Yoga/Gyrotonic session?____
Where did you hear of us (ie website,internet,friend)____
Are you currently under the care of a chiropractic physician?_____If so, who?____
Are you enrolling/interested in children's programs? Y / N Child's Name & Age ___________________________________
Are you interested in sports specific training? Running Triathelete Golf Equestrian Skating Other

Yes	No	Have you recently had?(Last 5 years)
___	___	Back Pain
___	___	Numbness
___	___	High Blood Pressure
___	___	Low Blood Pressure
___	___	Fatigue, Low Energy
___	___	Arthritis/Bursitis
___	___	Migraines/Headaches
___	___	Cardiac/Circulatory Problems
___	___	Diabetes/Thyroid
___	___	Bulging/Herniated Disc
___	___	Edema/Swelling
___	___	Fibromyalgia
___	___	Cancer
___	___	Infectious Disease
___	___	TMJ
___	___	Varicose Veins
___	___	Blood Clots
___	___	Epiletic
___	___	Pregnancy
___	___	Other explain:____

Medical History

Past Surgeries:____
____
____
____

Past Injuries/Fractures/Traumas: _________________________
____
____
____

Current Medications:______________________________________
____
____
____

Yes	No	
___	___	Do you wear contact lens

Allergies:

Yes	No	
___	___	Oils
___	___	Lotion
___	___	Fragrance

I understand that Movement Therapy/Massage should not be construed as a substitute for a medical examination, diagnosis or treatment, and that I should consult a physician or medical specialist for physical and mental ailments.

I understand that the Movement Therapy/Massage I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure or workload may be adjusted to my level of comfort.

Because Movement Therapy/Massage is contraindicative (should not be performed) under certain medical conditions, I affirm that I have stated all my medical conditions and answered all questions honestly. I agree to update the practitioner as to any changes in my medical profile and understand that there shall be no liability on the part of the practitioner should I fail to do so. I further understand that instructors/Massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of the sessions will be construed as such. It is also agreed that any illicit or sexually suggestive remarks or advances made by will result inimmediate termination of the session and I will be responsible for the payment of the session.

I understand 24 hours notice is required for cancellations, and I will be liable for that session if I fail to comply with the cancellation policy.

Signature:____Date:______________________________