LIVING ROOM YOGA

Your Place For Yoga Therapy & Healing

Yoga Therapy • Yoga Classes • Yoga Teacher Training • Hypnosis
Cranial Sacral Therapy • Massage Therapy • The Feldenkrais Method

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(727) 826-4754 • www.livingroomyoga.biz

New Student Form/Wellness Questionnaire for Massage Therapy

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____ - _____

Home Phone: (_____) _____ - _____

E-Mail*: _____

Birth Date: _____

Gender: ☐ Male ☐ Female

Emergency Contact: _____

Emergency Contact Relationship: _____

Emergency Contact Phone: (_____) _____ - _____

Name of Your Healthcare Provider: _____

Phone Number of Healthcare Provider: (_____) _____ - _____

Health Insurance Carrier _____

What kind of work do you do? _____

_____

Is your body comfortable at work? ☐ Yes ☐ No

* Living Room Yoga uses your e-mail address to send out updates regarding your account status, reminder updates for classes or workshops you have been booked into, special promotions/coupons, and our weekly studio update newsletter. Your personal information will never be sold to a third party. You can unsubscribe from our electronic communications at any time.

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

If you answer "yes" to any of the following questions, please explain as clearly as possible.

☐ Yes ☐ No Do you frequently suffer from stress? _____

☐ Yes ☐ No Do you have diabetes? _____

☐ Yes ☐ No Do you experience frequent headaches? _____

☐ Yes ☐ No Are you pregnant? _____

☐ Yes ☐ No Do you suffer from arthritis? _____

☐ Yes ☐ No Are you wearing contact lenses? _____

☐ Yes ☐ No Are you wearing dentures? _____

☐ Yes ☐ No Do you have high blood pressure? _____

☐ Yes ☐ No Are you taking high blood pressure medication? _____

☐ Yes ☐ No Do you suffer from epilepsy or seizures? _____

☐ Yes ☐ No Do you suffer from joint swelling? _____

☐ Yes ☐ No Do you have varicose veins? _____

☐ Yes ☐ No Do you have any contagious diseases? _____

☐ Yes ☐ No Do you have osteoporosis? _____

☐ Yes ☐ No Do you have any allergies? _____

☐ Yes ☐ No Do you bruise easily? _____

☐ Yes ☐ No Any broken bones in the past two years? _____

☐ Yes ☐ No Do you have cardiac or circulatory problems? _____

☐ Yes ☐ No Do you suffer from back pain? _____

☐ Yes ☐ No Do you have numbness or stabbing pains? _____

☐ Yes ☐ No Are you sensitive to touch or pressure in any area? _____

☐ Yes ☐ No Have you ever had surgery? _____

☐ Yes ☐ No Other medical condition, or are you taking any medications I should know about?

_____

☐ Yes ☐ No Do you have any tension or soreness in a specific area?

_____

Comments: _____

_____

What chronic conditions do you have? _____

_____

List any accidents or injuries with approximate dates: _____

_____

Have you ever experienced a professional massage or bodywork session? ☐ Yes ☐ No

How recently? _____

What are your massage or bodywork goals? _____

What kind of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

How Did You Hear About Us - *Please mark only one*

- ☐ Facebook Fan Page
- ☐ Referral by Member: _____
- ☐ Online Info Form
- ☐ Healthcare Provider: _____
- ☐ Driving By/Sign
- ☐ LinkedIn
- ☐ CrowdSavings
- ☐ Living Room Yoga Car
- ☐ Yelp
- ☐ St. Pete/Tampa Bay Times
- ☐ Tampa Bay Wellness Magazine
- ☐ Transformations Magazine
- ☐ Internet Search
- ☐ Flyer in Coffee Shop: _____
- ☐ Eversave
- ☐ LivingSocial
- ☐ Other: _____
- ☐ Bay News 9

Massage Therapy Liability Waiver

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience 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 further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I specifically agree that Living Room Yoga shall not be liable for any claim, demand, cause of action of any kind whatsoever for, or on the account of death, personal injury, property damage, or loss of any kind resulting from or related to my use of equipment or participation in yoga on my premises or the premises of Living Room Yoga. I agree to hold Living Room Yoga harmless from same.

I have read the above release and waiver of liability and fully understand its contents. I signify by signing below that I voluntarily agree to the terms and conditions stated above from this date forward in all my dealings with Living Room Yoga.

Printed Name _____

Signature _____ **Date** _____

Cancellation Policy Acknowledgement

By signing below, I agree to provide notice of cancellation by **Noon of the previous business day** in order not to be charged for the missed session. Weekend and Monday appointments must be cancelled by 12:00 noon on the Friday before in order not to be charged for the appointment.

Printed Name _____

Signature _____ **Date** _____

***Consent to Treatment of Minor*:** By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ **Date** _____