Karuna Health

Client Information

Name_____ Date _____

Address_____

City_____ State_____ Zip_____

Date of Birth _____ Age _____ Occupation _____

Cell Phone _____ Home Phone _____

Work Phone _____ Referred by _____

Email Address (this is not shared; it is for the purpose of receiving updates/newsletters from Karuna Health)
_____

Emergency contact_____ Phone _____

What are your goals in receiving massage?

What are the repetitive postures/motions that you perform at work/other setting?

What are your exercise activities?

Please list any current medications and their purposes:

Massage Informed Consent and Agreement

It is my choice to receive Thai or Western massage, and I understand that the session is intended for relaxation, muscle tension release, increased range of motion, improved circulation, reduced stress, increased energy flow and balance, and a positive opening experience. I understand that Thai or Western massage is not a substitute for medical treatment, examination, or medications, and that it is recommended to concurrently work with my primary caregiver for any condition that I may have. I have informed the Thai or Western massage practitioner of all my known physical and medical conditions and medications, and I will keep her updated to any changes in my health status. I understand that all information regarding my health history, the records of my sessions, and other personal information related to the session will remain in complete confidence. If this information is requested, I will release it under written consent. I will follow the **24-hour cancellation policy** via phone, or I will need to pay the full amount for the massage (unless it is an emergency situation). Please be on time. Thank you.

Signature _____ **Date** _____

Yuki Tsuji-Hoening RYT, LMT, RTT | 857-919-1548 | contact@karunahealthboulder.com

Karuna Health

Medical History

Please check all that apply to you
(Specify whether currently or previously)

Muscular-Skeletal

_____Headaches
_____Joint stiffness/swelling
_____Broken/Fractured Bones
_____Strains/Sprains
_____TMJ Dysfunction
_____Tendonitis
_____Bursitis
_____Sciatica
_____Arthritis
_____Osteoporosis
_____Scoliosis
_____Shoulder dislocation
_____Whiplash
_____Knee surgery
_____Hip replacement
_____Other_____

Nervous System

_____Numbness/Tingling
_____Sleep disorders
_____Cerebral Palsy
_____Epilepsy
_____Chronic Fatigue
_____Parkinson's Disease
_____Spinal cord injury
_____Carpal Tunnel Syndrome
_____Thoracic Outlet Syndrome
_____Disc herniation
_____Other_____

Circulatory/Respiratory

_____Dizziness/Fainting
_____Varicose veins
_____Blood clots
_____Stroke
_____Heart condition
_____Allergies
_____Asthma
_____Low/High blood pressure
_____Other_____

Digestive

_____Diverticulosis
_____Irritable Bowel Syndrome
_____Crohn's Disease
_____Colitis
_____Adaptive Aids
_____Diabetes
_____Other_____

Other

_____HIV
_____Fibromyalgia
_____Hearing impaired
_____Visually impaired
_____Surgeries_____
_____Drug use_____
_____Infectious disease_____
_____Depression_____
_____Other_____

Reproductive

_____Pregnancy
_____Menopause
_____Pelvic Inflammation Disorder
_____Endometriosis
_____Hysterectomy
_____Cesarean Section
_____Other_____

The information provided above is accurate to the best of my knowledge.

Signature_____ **Date**_____

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