



Thank you for taking the time to fill out this confidential questionnaire to help me determine the best treatment plan for your needs. If you have any questions, please ask.

Personal Information (Please Print)

Date: _____

Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ / _____

Cell Phone: _____ / _____

E-mail: _____

Mobile Provider: _____

Occupation: _____

Employer: _____

Employer Address: _____

Work Phone: _____ / _____

Date of Birth: ____/____/____ Age: _____ M / F Marital Status: _____

Emergency Contact: _____ Phone: _____ / _____

Relationship: _____

Have you received Deep Tissue Massage Therapy/ done Yoga before? Y / N

Referred by? _____

Did you injure yourself at work? _____ Y / N, Describe: _____

Medical Physician / Phone: _____

What treatments have you received for your condition?
Massage / Physical Therapy / Surgery_Acupuncture /
Chiropractic / Medication / Yoga/ Other

Have you had any surgeries in the last year? _____

Date when your symptoms appeared: _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

What makes it better? _____

What makes it worse? _____

- Type of pain:**
- | | | | |
|---------------------------------|------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Shooting | <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Swelling | <input type="checkbox"/> Other |

Please indicate if you have any of the following.

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Low Back/Sciatic Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Anxiety | <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Shoulder/Neck Pain | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Loose Stool | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Knee Problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscle Fatigue | <input type="checkbox"/> Unstable / Weak Muscles | |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Neck pain | <input type="checkbox"/> General Fatigue | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Low Energy |
| <input type="checkbox"/> Herniated Disks | <input type="checkbox"/> Easily Angered / Agitated | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Get Sick Often | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Depression | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Other |

List your major complaints, and rate the severity of each area on a scale from **1**(Least Pain) to **10** (Severe Pain):

Area: _____ / Pain Level: _____

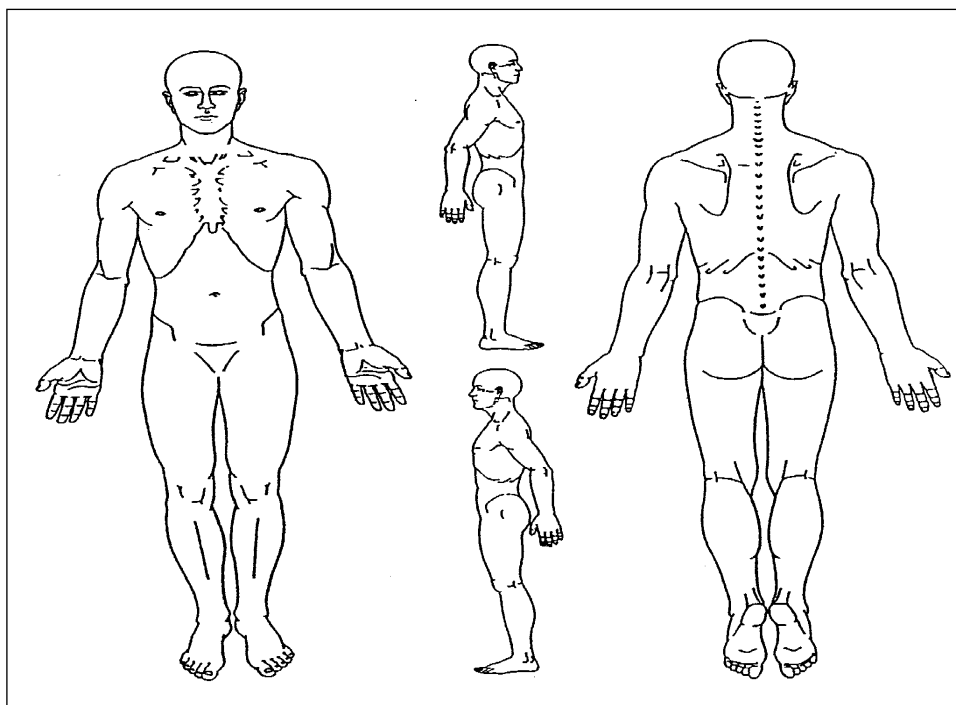
Area: _____ / Pain Level: _____

Area: _____ / Pain Level: _____

Area: _____ / Pain Level: _____

Area: _____ / Pain Level: _____

Please mark your areas of pain:



Payment Policy

I, the undersigned, understand and agree to the payment policy. I acknowledge that payment for all care received is my responsibility. **Payment is due at time of service** unless other arrangements have been made in advance with the office manager. We accept cash or checks. **I also understand that a 24-hour cancellation notice is necessary to avoid charges.**

Informed Consent

I hereby request and consent to the performance of Massage Therapy and other modalities and procedures by _____ . I understand that infrequently, a small amount of bruising, and or soreness may accompany a massage treatment/ yoga class. I have read the above consent and understand it.

Cancellation Agreement

We look forward to helping you at Serenity Stream Yoga and Wellness. The time you schedule is reserved just for you. Your treatment schedule is designed for optimal results. Missed appointments will hinder your progress. **The cost of the scheduled session fee will be charged for missed appointments or cancellations without 24 hours notification.** I have read, understand, and agree to the cancellation agreement.

(Client Signature)

(Date)