

Blue Skies Therapy
Kristi Johnson, L.M.T., R.Y.T.

L.M.T. License #043538

9430 Research Blvd, Bldg 1 Ste 170 Austin, TX 78759

I appreciate you filling out the information below. This information will help me meet your needs more effectively. All information is confidential.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____

Email: _____ Date of Birth: _____

What you want to gain from the yoga class and/or massage therapy: _____

Have you done Yoga before? Yes No

If so, explain (what kind, how much, when, etc.): _____

Check if you are you interested in:

Chair Massage

Table Massage

Thai Massage

Medical History (Check all that apply.):

Heart Disease

High Blood Pressure

Headaches

Skin Conditions

Low Blood Pressure

Tendonitis

Cancer

Osteoporosis

Bursitis

Diabetes

Contagious Conditions

Muscular Spasms

Epilepsy

Blood Clots

Muscle Sprains/Strains

Arthritis

Varicose Veins

Other/Describe: _____

Are you pregnant at this time? Yes No

Are you currently under care of a physician, therapist, or other health practitioner? Yes No

If yes, whom, and for what? _____

Please describe any:

Surgeries: _____

Major accidents, injuries, traumatic events, and illnesses: _____

Any other conditions or history that I should be aware of: _____

List any medications and pain relievers you take: _____

Are you currently experiencing any of the following? If yes, please explain.

Pain/Tenderness
 Numbness/Tingling
 Allergies
 Other: _____

Stress
 Stiffness
 Swelling

What is your pain on a level from 1-10 (10 being the worst pain): _____

Previous therapy and/or bodywork experience: _____

The preferred method of draping in my office is for you to be covered at all times. You only need to remove as much clothing as you are comfortable with. In some cases, such as stretching and movement exercises, you will be asked to wear workout clothes. Your modesty will be honored at all times.

I have provided all my known medical information. The general benefits of yoga and massage, possible yoga and massage contraindications, and the yoga class structure and massage therapy treatment have been explained to me. I acknowledge that yoga and massage are not a substitute for medical diagnosis and treatment. I hereby consent and understand there shall be no liability on the Yoga Instructor and Massage Therapist, because of my volunteer election to participate as a client with this Yoga Instructor and Massage Therapist. I have read and I fully understand this form in its entirety.

I understand that:

- * Massage therapy or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment of an illness.
- * Massage therapy/bodywork practitioners 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 session should be construed as such.
- * I have the right to terminate the session at any time, regardless of the reason.
- * Therapeutic bodywork and massage includes treatment of the arms, legs, torso, head, and neck.
- * If I am unable to keep an appointment, I understand that an 8-hour notice is required, otherwise, I will be charged for the time reserved.

Client's Signature: _____ Date: _____

Therapist's/Instructor's Signature: _____ Date: _____

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