RASĀYANA LLC
AYURVEDA | MASSAGE | YOGA

Massage & Bodywork Intake Form

The information disclosed is kept strictly confidential

Date: _____ Name_____Date of Birth _____
Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Partnership

Age_____ Height: _____ Weight: Past: _____Current:_____ Occupation: _____

Address: _____ State: _____ Zip:_____

Phone: _____e-mail (only for health info & promotions) _____

Emergency Contact:_____ Relation: _____

Emergency Contact Phone:_____

Are you currently under the care of family physician or any other health professional?
☐ Yes ☐ No If yes, please explain

Are you currently taking any medications (or supplements) and/or receiving any medical treatment for your health condition? If so, please identify them here along with their dosage:

How often do you exercise?
☐ Weekly once ☐ Weekly twice ☐ 3-4 days weekly ☐ 5-6 days weekly ☐ Every day ☐ Not at all

How long do you exercise? _____ What type of exercise? _____

Is your exercise: (choose one) ☐ Vigorous ☐ Moderate ☐ Light

Please circle any painful or tense areas as well as regions where you tend to hold your stress:

Head/face Low back Shoulders Neck Abdomen Legs/Feet
Arms/Hands Mid-back Other (please describe)_____

Please circle any of the following health issues that you have had *in the past year*.

Allergies: _____

Angina	Fibromyalgia	Irritable Bowel Syndrome	Stroke
Asthma	Heart disease	Insomnia	Surgery
Blood clot	Hepatitis	Migraines/Headaches	Varicose veins
Cancer	Herpes simplex	Phlebitis/Thrombosis	Whiplash
Carpal Tunnel Syndrome	Hospitalization	Pregnancy	Other:
Communicable diseases	Hypertension	Repetitive Strain Injuries	_____
Disk problems	Immune system conditions	Sciatica	_____

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Please indicate if you ***currently*** have any of the following:

	Symptom	Yes	No	Location: Please describe
1	Any areas of infection?			
2	Any areas of swelling, edema or tendency to swell?			
3	Any areas of numbness or altered sensation?			
4	Any areas of pain or tenderness?			

	Condition	Yes	No	Please Describe
5	Arthritis			
6	Cancer or Tumors			
7	Cardiovascular Diseases			*Please circle all that apply:* anemia, angina, arteriosclerosis, congestive heart failure, heart attack, heart murmur, hemophilia, hypertension, varicose or spider veins, other (please describe):
8	Diabetes			
9	Injuries			
10	Kidney, Liver or Urinary problems			
11	Respiratory Conditions			
12	Skin Conditions			*Please circle all that apply:* acne, abrasions/cuts, birthmarks/moles, bruises, dermatitis, eczema, herpes, hives, poison ivy/oak/sumac, psoriasis, skin tags, sunburns, warts, other(please describe):
13	Surgery			Date of Surgery: Describe:
14	Gastrointestinal Problems			
Other Medical Conditions not mentioned above				

Signature_____Date_____