Bari Ruck
Yoga, Massage, and Energy Healing
Intake Form

First Name_____ Date of Birth_____

Last Name_____ Referred by_____

Email Address_____ Best Phone #_____

Street Address_____ City_____

State_____ Zip Code_____

Emergency Contact Name_____

Emergency Phone Number_____

Date of Initial Visit_____

How would you rate your general health?

___Excellent ___Good

___Fair ___Poor

Have you had a professional massage before?

___If yes, what kind and when?_____

_____

___No

List current medications.

_____

_____

_____

_____

List and major accidents, Injuries or surgeries

_____

_____

_____

_____

Please list any allergies or sensitivities

_____

_____

_____

_____

What is the reason for your visit?

_____

_____

_____

_____

To the best of your knowledge, have you had or been exposed to COVID 19?

_____

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Please let me know if you have any of the following issues:

__Headaches/Migraines	__Vertigo/Dizziness	__Asthma
__High Blood Pressure	__Low Blood Pressure	__Chronic Cough
__History of heart attack	__Stroke	__Emphysema
__Poor Circulation	__Heart Disease	__Frequent Colds
__Phlebitis/varicose veins	__Pacemaker	__Shortness of Breath
__Hemophilia	__Chronic Congestive Heart Failure	__Bronchitis
__Family History of Heart Problem	__Sinusitis	__Smoker
__Loss of taste, smell or touch	__Numbness/Tingling	
__Sciatica	__Epilepsy	
__Seizures	__Multiple Sclerosis	
__Arthritis	__Osteoporosis	
__Tendonitis	__Bursitis	
__Jaw Pain	__Pins/Plates/Wires/Artificial Joints	
__Pregnant	__Recently given birth	
__Gynecological Issues	___Digestive Conditions	
__Hepatitis	___HIV/AIDS	__Fibromyalgia
__Herpes	___Tuberculosis	__Depression
__Lyme Disease	___Rash or Infectious Skin Condition	__Anxiety
__Cancer	__Diabetes	__Chronic Fatigue

Other Issues or comments:

I give my consent to receive a massage today. I understand the risks and the benefits of the treatment today. I acknowledge that massage is not a substitute for medical therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all the medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law.

Signature – Print and Sign_____ Date_____