

(CWS are independent practitioners. We are not owned or operated by Satchidananda Ashram, Yogaville)

All clients are requested to provide the information/waiver below. The information provided by you will be treated confidentially.

Full Name _____ Birthdate _____ Telephone _____
 Address _____ City _____ State _____ Zip _____
 Occupation _____ Referral Sources: _____
 Email (optional) _____

What program, if any, are you attending? _____
 Bodywork history (frequency, types) _____
 Any specific need or condition for this session? _____
 Is it difficult for you to lie on your front or back? Yes No How much do you exercise per week? _____
 How many hours of sleep per night? _____ hrs. How often do you have a bowel movement? _____ times/day.
 Smoking? Yes No Alcohol? Yes No Caffeine? Yes No List diet restrictions _____
 _____ . List allergies _____ . Do you do yoga? Yes No If so,
 often _____ per/week.

Past and present medical conditions (please circle)

Arthritis	Kidney conditions	Heart disease	Diabetes
Varicose Veins	Low/High blood pressure	Immune deficiencies	Seizures
Phlebitis	Herpes	Lung conditions	Fibromyalgia
Bruising	Epilepsy	Stroke	Cancer
Headaches	PMS	Liver problems	Blood disorders
Skin conditions	Current pregnancy		

Other: _____
 Surgery/fractures (please explain): _____
 Pain or stiffness in back, neck, shoulder, etc.: _____
 Emotional difficulty: _____

Do you wear: contact lenses dentures hearing aid prosthesis
 Are you under medical supervision? Yes No If so, for what? _____
 Are you taking medication? Yes No If so, please list? _____
 Do you experience stress? Yes No If so, how much? Little Average Great amounts.
 If so, from what? _____

I have requested treatment and confirm that the above information is correct. I recognize that the treatment is provided by an independent practitioner and not by the Community Wellness Services. I understand that the massage, energy, movement-education practitioner does not diagnose illness, disease or any other physical or mental disorder. The practitioner does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. This treatment is not a substitute for medical examination, and it is recommended that I see a physician for any physical ailment that I might have.

Signature _____ Date _____
 Practitioner _____

Please fill out an evaluation form after your session. This can be obtained from your practitioner, or in VV and LCC lobbies, next to the CWS intake forms. Please place into the CWS comments box also nearby. We thank you!