

Yoga Therapy and Massage
Health Survey

Red Building across from the Wine and Info Center
Upstairs in the loft of Bodies On Power
500 Railway Street
Penticton, BC V2A 7Y6
(250) 462-0151

* All information is confidential & no advertising will be sent to you.

Date: _____

Name: _____

Phone Number: (h) _____

(w) _____

(c) _____

Address: _____

Referral: _____

What therapies or treatments are you currently receiving or have you received in the past?

(Regarding the concern for which you are presently seeking treatment)

If you are on medication, please list:

Is there anything else concerning your health you should tell your therapist?

What is your main focus for coming in to receive these series of yoga/massage sessions?

Example: relaxation/ pain relief/ chronic pain/ injury prevention etc...

Acknowledgement and Waiver

I, _____, declare the above information to be accurate and true. I acknowledge that I understand that Yoga and related therapies are not medical procedures, and the Yoga Teacher/Therapist will not be providing a diagnosis of any health or medical problems or concerns, which I may have.

I understand that Yoga is a process of integration intended to facilitate wholeness, body awareness, and self awareness. I also understand that I am solely responsible for my health, safety, and well-being.

I agree that I will inform the Yoga Teacher/Therapist of any activity or movement that I feel is likely to cause me to injure myself. I therefore agree to hold the Yoga Teacher/Therapist harmless from all responsibility for any injury I may sustain during or as a result of my Therapy sessions.

Dated: _____

Signed _____

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Questions: (circle answer)

Have you ever had a massage before? Yes No

Type of touch preferred? Deep Light

(for therapy purposes deep pressure may be used to get the proper release)

Type of lubricant preferred? Oil Crème

Do you now have, or have you ever had:

Allergies? Yes No

Diabetes? Yes No

High blood pressure? Yes No

Heart condition? Yes No

Varicose veins? Yes No

Blood clots? Yes No

Spinal problems? Yes No

Migraines? Yes No

Head or neck injuries? Yes No

Any other relevant concerns:

Doctor's Name:

Doctor's Phone Number or City:
