
107 East First Street
Clayton, NC 27520
919-270-4892

# Confidential Client Information

Today's Date:_____

Name:_____ Date of Birth:_____

Street Address:_____

City, State_____ Zip:_____

Email:_____

Mobile phone #:_____ Other/Work# :_____

In Case of Emergency: name_____ relationship to you_____

Emergency contact phone # and email_____

Your Occupation:_____ Referred By:_____

**What is the purpose for this visit?**_____

Have you received massage/bodywork before?_____

If yes, how would you describe your experience?_____

On a scale of 1-10, rate you're average daily stress level:_____

Do you exercise regularly? If so, in what way and how often?

_____

Are you wearing contacts?_____

## Current Condition and Medical History

Are you under the care of a health provider? And for what reason?

_____

Are you taking any medications or nutritional supplements? If so, please list and give reason._____

**Please circle all numbers applicable to your present or past condition:**

| | | |
|---|---|---|
| 1. Allergies | 9. Depression | 17. Hypoglycemia/Diabetes |
| 2.Anemia | 10. Dizziness | 18. Kidney Disease |
| 3. Arthritis | 11. Fatigue | 19. Insommnia |
| 4. Blood Clots | 12. Fractures | 20. Muscle Cramping |
| 5. Cancer | 13.Gout | 21. Neck problems/whiplash |
| 6. Circulatory Problems | 14. Headaches | 22. Neurological Injury/Disease |
| 7. Constipation/Diarrhea | 15. Hernia | 23. Open wounds |
| 8. Contagious Disease | 16. High/low BP | 24. PremenstrualSyndrome |
| 25. Pregnancy | 27. Sinusitis | 28. Skeletal Injury/Disease |
| 26. Scoliosis | 29. Skin issues/Rash | 31. Areas of numbness/pain |
| 30. Stomach issues/Ulcer | 32. Varicose Veins | 33. Other |

***Please explain, by number any condition you circled:***

_____

_____

_____

_____

_____

# Office Policies

*Please take a moment to carefully read the following information and sign where indicated:*

I understand that the massage therapy I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my comfort level.

I understand that massage therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of.

I understand that massage therapy 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 given should be construed as such.

Because massage therapy should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability of the practitioner's part should I forget to do so. **I have signed and will sign before each massage session the two COVID-19 affidavits_____ (please initial)**

I agree that all services rendered to me are charged directly to me and I am responsible for payment unless prior arrangements have been made. **A 24-hour minimum notice is required for cancellations**. **We reserve the right to charge full price for any missed or un-cancelled appointments.** The exception to this rule is illness or emergency. For the purpose of preventing the spread of infectious or contagious illness (i.e. cold, flu); if I am or becoming ill I agree to act responsibly and cancel my appointment and no fees will be charged or owed. I also agree that if my practitioner is ill or becoming ill the same will hold true.

**Rates:**

| | | | |
|---|---|---|---|
| $75.00 | 60-minute session | $100.00 | 90-minute session |
| $45.00 | 30-minute session | $125.00 | 120-minute session |

Client Signature:_____ Date:_____

Therapist Signature:_____ Date:_____

**Thank you for your cooperation and the opportunity to help you with a truly effective therapeutic massage at Purna Yoga East. If you have any questions, please ask your therapist. We are here to assist you any way we can.**

*In good health,*
*Your Purna Yoga East Massage Therapist*

PURNA YOGA EAST
A YOGA & MASSAGE THERAPY STUDIO
est. 2009

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I_____ understand that any of these conditions elevates the risk of contracting Covid-19:

People 65 years or older
Chronic lung disease
Moderate to severe asthma
Heart conditions
Compromised or suppressed immunity
Severe obesity (body mass index of 40 or higher)
Diabetes
Chronic kidney disease
Liver disease

I understand that close contact with people increases the risk of infection from COVID-19. *By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage from this practitioner.*
I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

_____ _____

Signature Date


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To best protect your health and the health of others, please fill out this form before each massage and bodywork session. Thank you!

NAME: _____ DATE: _____

Have you been tested for COVID-19? If yes, what type of test did you have?

When was your test? What were the results?

Have you been in places with a high infection rate within the last two weeks (e.g., state- designated "hotspots")? If yes, please explain.

Please check if you are experiencing any of the following as a NEW PATTERN since the beginning of the pandemic:

__ Fever
__ Chills
__ Cough
__ Sore throat
__ Diarrhea, digestive upset
__ Nasal, sinus congestion
__ Loss of sense of taste or smell
__ Fatigue
__ Shortness of breath
__ Sudden onset of muscle soreness (not related to a specific activity)
__ Rash or skin lesions (especially on the feet)

Do you have any new discomfort with exertion or exercise?

I declare that the information provided above is true and accurate to the best of my knowledge.

_____ _____

Signature Date