Personal Health Information - CONFIDENTIAL

WELCOME! I would like to make your experience as beneficial and comfortable as possible.
Please complete these forms by filling in the blanks (___) and circling capitalized options (i.e.: YES NO).

CONTACT INFORMATION **TODAY'S DATE:** _____

Name:_____ *Day of birth*:_____

Address:_____

Phone 1:_____ CELL HOME WORK *Phone 2*:_____ CELL HOME WORK

Email:_____

Preferred method(s) of contact: PHONE CALL TEXT MESSAGE EMAIL

Emergency Contact Name:_____ *Phone*:_____

GENERAL HEALTH

Reason for an appointment? Please circle any options or describe the incident, symptoms, treatments, etc.:

RELAXATION STRESS REDUCTION INJURY/PAIN INCREASE FLEXIBILITY
INCREASE BODY AWARENESS INTEGRATION OF BODY-MIND EMOTIONS ENERGY HEALING

OTHER:_____

_____

_____

Do you have any long term health goals?

_____

_____

_____

_____

_____

_____

_____

Do you have any allergies (oils, skin products, medication, food, etc.)? Please explain:

_____

_____

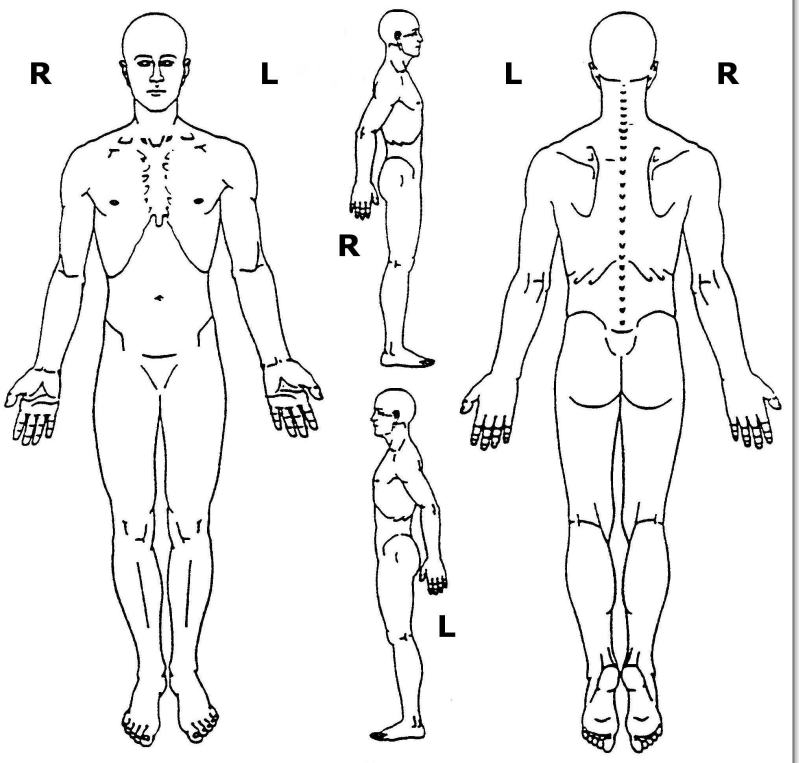
_____

_____

_____

_____

Please mark areas of concern on the chart:



MEDICAL HISTORY

Please circle any conditioning affecting you now or in the past, and elaborate below:

MUSCULOSKELETAL

Spinal / Disk Problems
Arthritis / Tendonitis / Bursitis
TMJ / Jaw Pain / Grind Teeth
Broken Bone / Dislocation / Sprain
Artificial Joint / Implant
Osteoporosis
Other:_____

CIRCULATORY

Heart Condition
Blood Pressure: High or Low
Blood Clots / DVT / Embolism
Varicose Veins / Phlebitis
Stroke
Lymphedema
Other:_____

RESPIRATORY

Asthma / Breathing Difficulty
Cold / Flu / Sinus Problems
Other:_____

NERVOUS SYSTEM

Pinched Nerve /Sciatica /Numbness
Headaches / Migraines
Anxiety / Panic / Depression
Chronic Fatigue / Fibromyalgia
Seizures / Epilepsy / Convulsions
Auto–Immune:_____
Other:_____

REPRODUCTIVE

Menstrual / Ovarian Problems
Pregnancy: # Months:_____
Other:_____

SKIN

Bruise Easily
Cuts / Wounds / Sores
Any Rash / Skin Condition
Other:_____

DIGESTIVE/ABDOMINAL

Constipation / Diarrhea / IBS
Other:_____

OTHER

Cancer / Tumor
Diabetes
Inflammation / Swelling
Pain: Acute / Chronic
Surgery / Injury
Alcohol / Tobacco / Caffein / Drugs
Other:_____

Please elaborate on any condition checked above or not listed:_____

_____

_____

_____

Are you taking any medications or dietary supplements? Please explain: _____

_____

Are you seeing a healthcare professional? If yes, please list name, phone, and reason/treatment:

_____

_____

_____

CONSENT & WAIVER

I,[PRINT NAME] _____, affirm that I have stated all known conditions and answered all questions to the best of my ability. I consent to receive instruction/application of myomassology, yoga, meditation, breathing exercises, etc. from Jasen Hum ("Jasen"). I agree to keep Jasen and my health care provider up to date as to any changes in my medical profile and understand that there shall be no liability on Jasen's part should I fail to do so.

If I experience pain or discomfort, I will immediately inform Jasen so that the technique can be adjusted to my level of comfort, or stopped altogether.

I acknowledge that yoga may be physically strenuous and I voluntarily participate with full knowledge that there is a risk of personal injury; and I assume responsibility for said risks.

If I am uncomfortable for any reason, I may ask that the session be stopped immediately.

I agree to provide at least 24 notice to reschedule or cancel a scheduled appointment. Failure to notice may result in a $25.00 no show/late cancellation fee, which must be paid prior to my next session.

I am hereby informed that Jasen practices under common law, as guaranteed by the Ninth Article of the Bill of Rights [1791], a.k.a. the Seventh Amendment to the Constitution for the united States of America [1791].

Signature:_____ Date:_____