CLAIRE COETZEE

reflexology • yoga • massage

CONSENT FORM

Please full in your details in the form below

SURNAME:_____ FIRST NAME:_____ DOB:_____

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐

ADDRESS:_____

_____

_____ CODE:_____

TEL (H):_____ TEL (W):_____ CELL:_____

OCCUPATION: _____ EMAIL:_____

NEXT OF KIN

NAME & SURNAME:_____

RELATIONSHIP:_____ CONTACT NO._____

SIGN:_____ DATE: _____

What is Thai Yoga Massage:

Thai Yoga Massage uses gentle pressure and stretching techniques to relax the whole body. This is an ancient healing practice designed to relax the nervous system and move Qui energy around the body aiding more balance and overall well-being.

What do you hope to get out of your massage session (mark all that apply):

☐ Stress Relief ☐ Joint Health ☐ Pain Reduction ☐ Improved digestion ☐ Improved sleep ☐ Other: _____

Health History:

1.Please list your current and previous health conditions.

_____

2.Please list medical diagnoses, surgeries, accidents, and/or injuries followed by the approximate date:

_____

3.Are there any other health problems or life challenges that you wish to share?

_____

4.If your primary reason for the personal session is a health-related, please indicate the current health condition and the length of time you have been dealing with it (e.g. back pain, 1 year; e.g. insomnia, 5 years):

_____

5.Describe your lifestyle.

- Do you watch what you eat? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never
- How often do you exercise and what kind of exercise do you do?_____
- Do you smoke? ☐ Yes ☐ No If yes, frequency:_____
- Do you drink? ☐ Yes ☐ No If yes, frequency:_____
- In percentages, please indicate how much of your day you are in the following positions:
  Sitting:__% Standing:__% Lifting: __% Driving: __% Computer or desk work: __% Lying down: __% 12.

6.What is your CURRENT perceived stress level – low, moderate, or high?_____

7.Describe your sleep habits; for example:

- Do you get enough sleep? _____
- How many hours/night do you need to feel refreshed? _____
- Do you wake up frequently during the night? _____
- Do you have an established bedtime routine? _____

8. How would you describe your breathing patterns? Check all that apply:

☐ Shallow, chest breathing ☐ Deep and rhythmic ☐ I don't think about my breath

9. How often do you spend time in nature?_____

I have read and understand the above and am receiving treatment at my own request.

SIGN:_____