

# J'Adore Dance's Yamuna® Body Rolling Intake Form

All information on this form will be kept confidential and is only used by Chantel for individual programming considerations. Health concerns, previous injuries, chronic conditions, etc must be taken into consideration when rolling through certain areas of the body. Providing accurate information is essential to providing a safe and effective experience in class.

Name \_\_\_\_\_ DOB (DD/MM/YY) \_\_\_\_\_

Phone (day) \_\_\_\_\_ (evening) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Preferred Email \_\_\_\_\_

Preferred Method of Contact from above: \_\_\_\_\_ Occupation \_\_\_\_\_

Have you attended a Yamuna Body Rolling Class before?  yes  no If yes, Location/Instructor \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Are you currently pregnant?  yes  no

If yes, how far along? \_\_\_\_\_

Any high risk factors? \_\_\_\_\_

Do you suffer from chronic pain?  yes  no

If yes, please explain \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Have you had any orthopedic injuries?  yes  no

If yes, please list: \_\_\_\_\_

Please indicate any of the following that apply to you.

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Fibromyalgia       |
| <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart Attack       |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s)    | <input type="checkbox"/> Blood Clots        |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness           |
| <input type="checkbox"/> Neuropathy              | <input type="checkbox"/> Sprains or Strains |
| <input type="checkbox"/> Disc Herniation         | <input type="checkbox"/> Fractures          |
| <input type="checkbox"/> Nerve impingement       | <input type="checkbox"/> Anxiety            |
|  | <input type="checkbox"/> Depression         |

Explain any conditions you have marked above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any recent abdominal surgeries?  yes  no  
IF YES, must wait 8-12 weeks for complete healing.

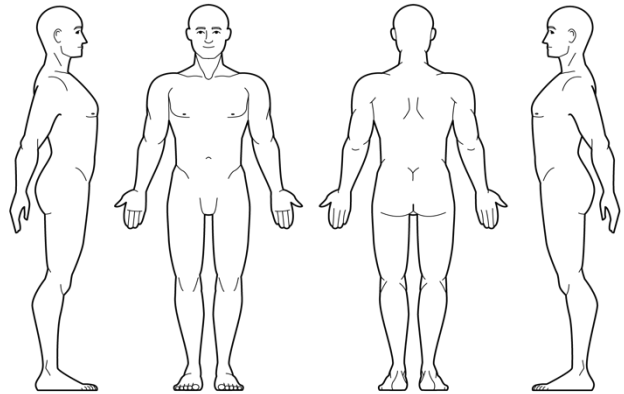
Have you had any Previous surgeries?  yes  no

What areas of the body? \_\_\_\_\_

Do you have any allergies or sensitivities?  yes  no

Please explain \_\_\_\_\_

Please circle any areas of discomfort



The following helps to determine level of comfort on the ball and with hands on assists.

Have you had a professional massage before?  yes  no

Relaxation  Therapeutic/Deep Tissue

Other \_\_\_\_\_

What pressure do you prefer?

Light  Medium  Deep

Have you had any of the following:

- Chiropratic Adjustments
- Active Release
- Physical Therapy
- Body Logics

Are you comfortable with Hand on Assits during class?

yes  no