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COMPREHENSIVE CLIENT INFORMATION & WAIVER
Fascial Stretch Therapy

Instructions: This is your comprehensive information sheet. All relevant, personal information is gathered to equip the therapist with essential information used to deliver an optimal, results driven program. Please answer all questions accurately, honestly, and as detailed as possible.

Part 1: Basic Information

How did you hear about us? _____ *(if referred, please mention the name of the client so we can provide them with a $15 discount on their next treatment)*

Name: _____ Gender: _____ D.O.B: _____/_____/_____ Age_____

Email: _____ Contact Number: _____

Address: _____

Part 2: Session Information

What is you main reason for receiving therapy? _____

What specific goals would you like to receive from therapy? _____

How did your symptoms begin? _____ When did symptoms begin? _____

Please mark on the figures where symptoms are located:

Are you currently, or have been, under medical supervision for this problem? YES _____ NO _____

Have you had any tests for this problem (x-rays, MRI, CT-scan)? _____

Please describe your symptoms. Circle all that apply:

-Dull -Ache -Burning -Sharp -Periodic -Constant

-Sore -Stiff -Numb -Tingling

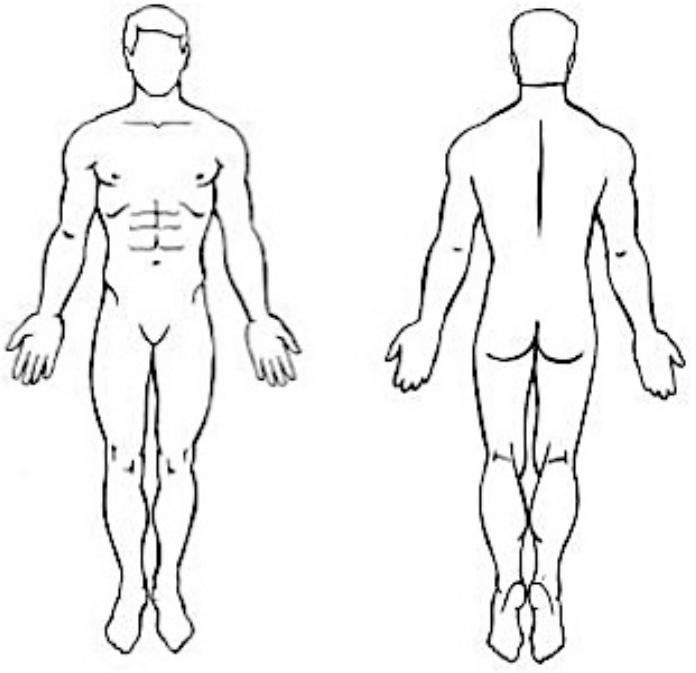
What makes your symptoms better or worse?

_____

_____

Do you have chronic or frequent pain? _____

On a scale from 1-10, 10 being the most severe pain possible, what is your discomfort level now? _____



Part 3: Physical/Lifestyle Factors

Please list any supportive braces worn? _____ Do you wear orthotics? YES_____ NO _____

Have you ever had chiropractic treatment? YES _____ NO _____ How often? _____

Have you experienced any bodywork (massage, acupuncture, etc)? YES _____ NO _____ If so, what type? _____

How often do you receive bodywork? _____

Are you currently exercising regularly? YES___ NO ___ How does exercising impact your symptoms? _____

Do you currently stretch? YES ___ NO __ If so, how often? _____

Do you believe flexibility is an important part of fitness and overall health? YES _____ NO _____

What percentage of your day is spent sitting? _____ Standing? _____ Driving? _____ Physical Labor? _____

How do you rate your posture? _____

Part 3: Medical History

Have you been diagnosed with any health problems? If so, please list the condition(s): _____

_____

Are you currently on any medications (including over-the-counter medication like ibuprofen)? If so, please list them.

_____

Please list any supplements that you are currently taking: _____

Are you currently under care of a physician? YES _____ NO _____ If yes, please explain: _____

Please list any injuries, accidents or surgeries and date of event: _____

_____

Are there any other medical conditions that the therapist should be aware of? _____

The above information is accurate and true to the best of my knowledge. If there are any changes in my current level of health, I will inform the person I am being treated by of my condition. I understand that this business does not diagnose or treat illness and/or disease and does not prescribe medications. I agree to pay my account with this business in accordance with the regular rates and payment terms. If, for any reason cancellation is necessary, I will give a 24-hour notice. I understand that if I do not give this notice, I will be charged for the appointment. The owner will determine emergency cancellations. It is agreed that any claim of liability is hereby waived.

_____ _____

Signature Date

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Client Waiver Form
Fascial Stretch Therapy

Please take a moment to read and initial the following information:

_____I understand that fascial stretch therapy (FST) is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation, range of motion and energy flow.

_____If I experience pain or discomfort during the session, I will immediately inform my practitioner so that pressure can be adjusted to my level of comfort. I will not hold my practitioner responsible for any pain or discomfort I experience during or after the session.

_____I affirm that I have notified my practitioner of all known medical conditions and injuries.

_____I agree to inform my practitioner of any changes in my health and medical condition. I understand that there shall be no liability on the instructor's part should I forget to do so.

_____I understand that stretch therapy sessions are designed to assist in greater stretch gains and are non-sexual in nature.

_____I understand that there is a **24-hour cancellation policy**. If I am unable to cancel before that time I will be responsible for the costs associated with that session.

_____I agree that in the event my insurance refuses payment for any session, I am fully responsible for paying my outstanding balance.

_____**I** understand that the services offered today are not a substitute for medical care. I understand that my practitioner is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

By signing this release, I hereby waive and release my practitioner from any and all liability, past, present, and future relating to these fascial stretch sessions/bodywork.

I have read and agree to these policies therein.

Client Name:_____

Client signature:_____

Parent signature (if under 18yrs):_____

Information and Suggestions

- Prior to your stretch, please remove jewelry or watches.
- Pull long hair back with a clip or band.
- Please wear loose, comfortable clothing that allow for freedom of movement.
- Feel free to ask your practitioner any questions before, during, or after the session.