Client Information

Name ____ Phone (   ) _____________________DOB _________________

Address ____ City _______________ State _________ Zip _________

Email ____

Referred by: ____ Phone (   ) _____________________________

In Case of emergency ____ Phone (   ) _____________________________

Occupation __________________________________ Male __ Female __ Physician ___________________________________

Health Insurance Carrier ____ Cell Phone carrier? __________________

__Yes __ No Do you have diabetes?
__Yes __ No Are you pregnant?
__Yes __ No Do you have high blood pressure?
__Yes __ No Do you have tension or soreness in a specific area? Please specify ______________________________________

__Yes __ No Do you suffer from back pain?
__Yes __ No Do you suffer from joint pain?
__Yes __ No

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I understand that the stretch therapy I receive is provided for the basic purpose of relief of muscular tension and the promotion of increased flexibility. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure of the stretch may be adjusted to my level of comfort. __________

I further understand that this stretch therapy should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, or qualified medical practitioner for that physical ailment for which I am aware. __________

I affirm that there are no known suggested medical reasons as to why I cannot be stretched _________

I affirm that I have discussed with practitioner any medical concerns that may interfere with my stretch therapy session today and that there shall be no liability on the practitioners part should I fail to do so.
____

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment which is maybe due. __________

Clients Signature _______________________________________ Date ___________________

Practitioners Signature _________________________________ Date ___________________

Consent to Treatment of Minor: By my signature below, I hereby authorize ____
to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.
Signature of Parent or Guardian ____
Date __________