Stretch Intake Form

Personal Information

Name ______________________________________ Phone (Home) _____________________________ (Cell) ______________________

Address ____________________________________ City/State/Zip ____ DOB ___________

Email ____Occupation ____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, are they blood thinners or for high blood pressure? ☐ yes ☐no

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 ___________________________________

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: _______________________________________

Are you in significant pain? How severe is the pain (using scale of 1 to 10 with 10 being the most severe - having to go to ER)

1 2 3 4 5 6 7 8 9 10

Please indicate any of the following that apply to you.

☐ Inflammation	☐ Surgery
☐ Cancer	☐ Infection
☐ Arthritis	☐ Fibromyalgia
☐ Diabetes	☐ Stroke
☐ Joint Replacement (s)	☐ Blood Clots
☐ High/Low Blood Pressure	☐ Numbness
☐ Neuropathy	☐ Loss of Mobility
☐ Osteoporosis	☐ Sprains or Strains
☐ Headaches/Migraines	☐ Dislocation/Fractures

Explain any conditions you have marked above:

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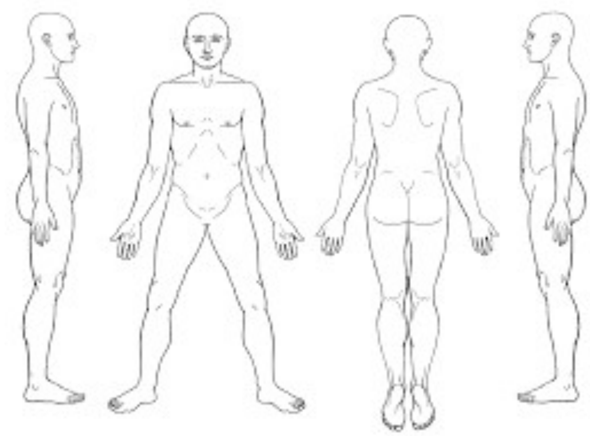
Stretch Information

Have you had a professional stretch before? ☐ yes ☐ no

Please circle any areas of discomfort



I understand that stretch therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation, assist in greater stretch gains of range of motion and energy flow. ☐ yes

If I experience pain/discomfort during the session, I will immediately inform my therapist so that pressure can be adjusted to my level of comfort. I will not hold my therapist liable should I choose to not say anything if I have pain/discomfort. ☐ yes

I understand assisted stretching can involve close contact, if at any time I feel uncomfortable session will pause or conclude

I understand that there is a [illegible] cancellation policy, [illegible] unable to cancel before that time I will be responsible of the costs associated with that session and may be required to pay prior to any additional session. [illegible] allotted time remaining may be utilized and I'm responsible for the full payment. ☐

Client Signature ________________________ *Date* ____________

Therapist Signature ______________________ *Date* ____________