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:

_____

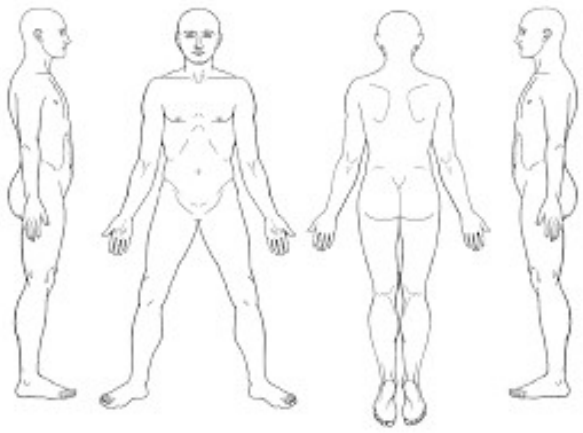
_____

_____

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 that there is a 24-hour cancellation policy. If I am 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 sessions. If I arrive late to my appointment, only the allotted time remaining may be utilized and I'm responsible for the full payment. ☐ yes

I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____*Date* _____

Therapist Signature _____ *Date* _____