Stretch Intake Form

Name:_____Phone:_____DOB:_____

Address:_____Ctiy/State/Zip:_____

Email:_____Occupation:_____

Chiropractic Patient of Dr. Kara or Dr. Katie? If so who?_____

Do you have any musculoskeletal disorders such as Arthritis, Osteoporosis, Bursitis, Tendonitis, Pins/Plates/Wires or any artificial joints? If Yes What/Where/When:_____

_____

_____

Do you have any skin disorders or other health infections such as Hepatitis, Herpes, HIV/AIDS, TB, Lyme disease, etc.? And if so what: _____

Are you in or do you have significant discomfort? If so please describe: _____

_____

_____

Any additional health concerns/issues:_____

_____

____I understand that the services offered today are not a substitute for medical care nor a substitute for any medical examination or diagnosis and services are not billable to my insurance.

____I understand that the services offered today are not a substitute for medical care nor a substitute for any medical examination or diagnosis and services are not billable to my insurance.

____I understand that assistive stretching / Fascia Stretch Therapy / FST / massage /Myoskeletal bodywork 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.

____I understand that if I have purchased a package deal, my missed or late cancelation will be counted as one of the sessions. If I arrive late to my appointment, only the allotted time remaining will be utilzed and I'm responsible for the full payment.

____I am over the age of 18. If the answer is No - you MUST be accompanied by an adult for in person sessions, and an adult over 21 MUST be present for virtual/online sessions. NO EXCEPTIONS.

By signing this release, I hereby waive and release my practitioner, Jeanette Lamb, Active Stretch Therapy and all staff, affiliates or contractors from any and all liability, past, present, and future, whether in person or virtual/online, relating to assistive stretching / Fascia Stretch Therapy / FST. I Affirm that I have notified my therapist of all known medical conditions and injuries and will notify of any changes to my health or medical conditions. I am also choosing to come in for treatment and will not attend if I feel that my health is at risk or am a risk to others. Cancelation fees are waived and packages will be extended for Covid and other contagious diseases or outbreaks that may impact the health and safety of anyone. We are committed to providing a welcoming, safe, comfortable place and environment for everyone regardless of orientation.

_____ _____ _____

Patient/Guardian Name **Patient/Guardian Signature** **Date**