Gym Integrity

Tel: 405-919-5692 E-mail: gymintegrity@outlook.hu Website: gymintegrity.com

Client Intake Form

Name: _____ Phone #: _____

Address:_____Apt. #: _____

City:_____ State:_____ Zip: _____

Email:_____

Date of Birth:_____Occupation:_____

Referred by:_____

Emergency Contact:_____

Phone #:_____

General and Medical Information

Y N Are you under the care of a physician? If so, why?

_____

_____

Y N Have you ever had a stretch session? If yes, how often? What kind?

_____

_____

Y N Pregnant?

Y N Do you suffer from seizure disorders or epilepsy?

Y N Diabetic? If yes is your diabetes under control?

_____

Y N Broken any bones in past two years? Which?

_____

_____

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Y N Cardiac or circulatory issues? Please explain.

_____

_____

Y N Have you ever had surgery? If yes, please explain.

_____

_____

_____

Y N Do you have any other medical conditions, major accidents or injuries?

_____

_____

Y N Current medications? What for?

_____

_____

What is your reason or goal for receiving Fascial Stretch Therapy?

_____

_____

Client Waiver Form

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

_____I understand that Fascial Stretch Therapy 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.

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_____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 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 József Szendrei (Yoyo's Gym LLC DBA Gym Integrity) from any and all liability, past, present, and future relating to these fascial stretch therapy sessions/bodywork.

I have read and agree to these policies therein.

Client name:_____

Client signature:_____

Client e-mail:_____

Parent signature (if under 18 yrs):_____

Date:_____

Information and Suggestions

* Prior to your stretch, please remove jewelry or watches. Pull long hair back with a clip or band.

* Please wear loose, long, comfortable clothing that allow for freedom of movement.

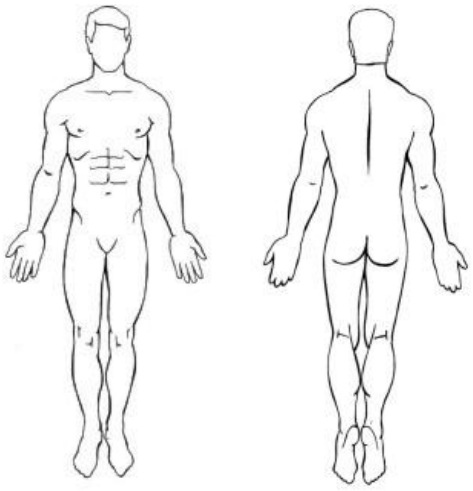
* Feel free to ask your practitioner any questions before, during, or after the session. Your practitioner is a highly trained professional and will be happy to make you feel informed and comfortable.

New Client Intake Form

Name: _____ Date: _____ Referred By: _____
Address: _____ Phone – Work: _____
City/State/Zip: _____ Phone – Home: _____
Birthday: _____ Mobile: _____
Occupation: _____ E-Mail: _____
Emergency Contact: _____ Phone: _____

General Information:

What is your main reason for coming to therapy? _____
What specific goals would you like to achieve from therapy? _____
_____
How and when did the symptoms begin? _____
Where are your symptoms located? Please mark the areas on the figures below:



How long have you had these symptoms? _____
Are you currently, or have you ever been, under medical supervision for this problem? _____
_____
Have you had any tests for this problem; such as x-rays, MRI or CT scans? _____
Describe the symptoms. Please check all that apply:
□ Dull □ Ache □ Burning □ Sharp □ Periodic □ Constant □ Sore □ Stiff □ Numb □ Tingling
What makes it better or worse? _____
_____
On a scale of 0 to 10 with 10 being the most severe imaginable discomfort, what is your discomfort level right now? _____
What time of day is the pain worse? _____
Do you have trouble sleeping? If yes, what position do you sleep in? _____

Physical Factors:

What physical activities are you currently involved in? _____
Do you stretch now? _____
Do you feel flexibility is an important part of fitness? _____
Have you ever had chiropractic treatment? If yes, how long, how often and with whom? _____

Have you ever seen a Naturopathic doctor? _____
Have you experienced any kind of bodywork before (i.e. massage, acupuncture, etc.)? If yes, what type? _____

Do you wear any type of supportive braces anywhere? _____
Do you wear orthotics? _____ If yes, for how long? _____
What percentage of your day is spent sitting? _____, standing? _____, driving? _____
Are your symptoms worse at the end of the workday? _____
Does your work station give you support and encourage good posture? _____
How would you rate your own posture? _____

Medical History

Please list any recent injuries, illnesses, or surgeries: _____
_____
_____
Are you currently under the care of a physician? Yes_____ No_____
If yes, please explain.
_____
List current medications, including aspirin, ibuprofen, etc. _____
_____

Please check all that apply

____ Cancer	____ Hi/Low Blood Pressure	____ Epilepsy
____ Digestion Problems	____ Elimination Problems	____ Ulcers
____ Cancer: Type _____	____ Respiratory Problems	____ Cold Hands/Feet
____ Migraines/Headaches	____ Sinus Problems	____ Heart Problems
____ Back Problems	____ Neck Problems	____ Bruise Easily
____ Sciatica	____ Arthritis/Bursitis	____ Allergies
____ Stroke	____ Immune Disorder	____ Fibromyalgia
____ Scoliosis	____ TMJ	____ Carpal Tunnel
____ Osteoporosis	____ Tendonitis	____ Asthma
____ Diabetes	____ Now Pregnant	____ Immovable Joints

Do you have any chronic or frequent pain? _____
Have you had any accidents, auto or other? _____
Have you ever had any major surgeries? _____
Have you ever had a head injury? _____ Have you noticed dizziness? _____ Change in hearing? _____
Change in vision?_____
Are there any other medical conditions the therapist should be aware of? _____
Are you pregnant? _____ If yes, how far along are you? _____

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 here that I'm seeing of my condition. I understand that this office does not diagnose or treat illness or disease and does not prescribe medications. I agree to pay my account with this office 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 unless it can be filled. Emergency cancellations will be determined by owner. It is agreed that any claim of liability is hereby waived.

_____ _____
Signature Date