

# Gym Integrity

Tel: 405-919-5692 E-mail: [gymintegrity@outlook.hu](mailto:gymintegrity@outlook.hu) Website: [gymintegrity.com](http://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?

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

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Y    N    Pregnant?

Y    N    Do you suffer from seizure disorders or epilepsy?

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

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

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Y      N      Cardiac or circulatory issues? Please explain.

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

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

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Y      N      Current medications? What for?

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

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## 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.

