Fascial Stretch Therapy (FST)

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

New patient form

Name: _____ Phone #: _____

Address:_____ Apt. #: _____

City: _____ State: _____ Zip: _____

Email: _____

Date of Birth: _____ Occupation: _____

Referred by: _____

Emergency Contact: _____

Phone #: _____

General and Medical Information

Please list any exisiting physical conditions, pains, injuries you have

_____

_____

_____

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 and goals 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.

_____ 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 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. 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.