pliability stretch™

HEAD2TOE
BODYSTRETCH AND MASSAGE

Medical History

In order to plan a stretch session that is safe and effective, I need some general information about your medical history.

9. Are you presently under medical supervision? Yes No

If yes, please explain _____

10. Do you see a chiropractor? Yes No If yes, how often? _____

11. Are you currently taking any medication? Yes No

If yes, please list _____

12. Please check any condition below that applies to you:

☐easy bruising
☐recent accident or injury
☐recent fracture
☐recent surgery
☐recent accident or injury
☐artificial joint
☐sprain/strains
☐current fever
☐swollen glands
☐allergies/sensitivity
☐heart condition
☐high or low blood pressure
☐varicose veins
☐atherosclerosis
☐pregnancy in last 12 months
If yes, time of pregnancy _____

☐phlebitis
☐deep vein thrombosis/blood clots
☐joint disorder/ rheumatoid
☐arthritis/osteoarthritis/tendonitis
☐osteoporosis
☐epilepsy
☐headaches/migranes
☐cancer
☐diabetes
☐decreased sensation
☐back/neck problems
☐Fibromyalgia
☐Carpel Tunnel Syndrome
☐tennis elbow

Please explain any conditions you have marked above _____

13. Is there anything else about your health history that you think would be useful to your trainer to know to plan a safe and effective stretch session for you? _____

14. What is your weekly fitness routine? _____

_____

Client Intake Form

Personal Information:

Name _____ Phone (DAY) _____ Phone (Eve) _____

Address _____

City/State/Zip _____

Email_____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

The following information will be used to help plan safe and effective stretch sessions. Please answer the questions to the best of your knowledge.

Date of initial visit_____

1. Have you had a professional stretch session before? Yes No

   If yes, how often do you have a stretch session? _____

2. Do you have any difficulty lying on your front, back or sides? Yes No

   If yes, please explain _____

3. Are you wearing contact lenses ( ) hearing aid ( ) or dentures ( )?

4. Have you been pregnant in last 12 months? Yes No

5. Do you sit for long hours at a workstation, computer or driving? Yes No

   If yes, please describe _____

6. Do you experience stress in your work, family or other aspects of your life? Yes No

   If yes, how do you think it has affected your health?
   muscle tension ( ) insomnia anxiety ( ) irritability ( ) other _____

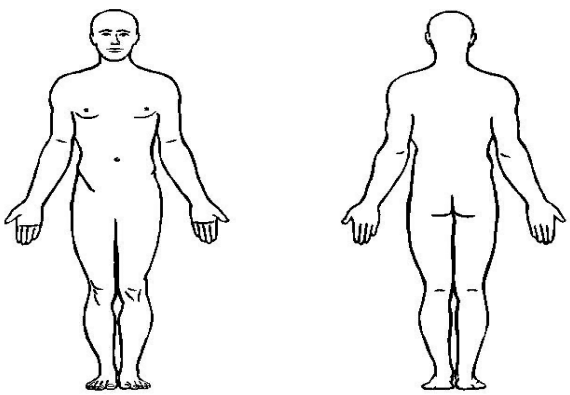
7. Is there a specific part of your body where you are experiencing stiffness, tension, pain or other discomfort?

   Yes No If yes, please identify _____

8.. Do you have any goals in mind for this session? Yes No

   If yes, please explain_____

Circle any areas you would like the specialist to work on during your session.



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PRIVACY NOTICE

Under the Health Insurance and Portability and Accountability Act "HIPAA" there are uses and disclosures of your information that we may perform without your specific authorization because that is the intent of our relationship. We disclose only the minimum amount of

This office may use and disclose your protected health care information for any of the following reasons:

- **To share with other treating health care providers regarding your health care**
- **To submit to insurance companies, No Fault carriers or Workers Compensation carriers to verify that treatment has been rendered and or receive payment**
- **To determine client benefits in a health care plan or under No-Fats lt or Workers' Compensation**
- **Release of information required by State or Federal Public Health Law**
- **In response to a court ordered subpoena for medical records**
- **To assist in overcoming a language barrier when caring for a patient**
- **Business associates-obtaining written assurances for your privacy**
- **Emergency situations**
- **Abuse, neglect, or domestic violence**
- **Appointments reminders to household members or answering machines**

You have the right to:

- **Revoke authorization in writing at any time by specifying our restrictions and to whom these restrictions apply**
- **Inspect your protected health information**
- **Obtain an accounting of disclosures of your protected health information**
- **Render a complaint to this office at 71/864-9628 or the Secretary of Health and Human Services**

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. A copy may be obtained by request.

I acknowledge that I have received and reviewed this notice with full understanding

Client Name: _____ ***Signature*** _____ ***Date*** _____