Stretch Intake Form South Shore Bowen Therapy

Personal Information

Name _______________________________________ Phone (Home) ______________________________ (Cell) ______________________

Address _____________________________________ City/State/Zip ____ DOB ____________

Email ____Occupation ____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, are they blood thinners or for high blood pressure? ☐ yes ☐no

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? ____________________________________

Any high risk factors? ____________________________________

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain ____________________________________

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: ____

Are you in significant pain? How severe is the pain (using scale of 1 to 10 with 10 being the most severe - having to go to ER)

1 2 3 4 5 6 7 8 9 10

Please indicate any of the following that apply to you.

☐ Inflammation	☐ Surgery
☐ Cancer	☐ Infection
☐ Arthritis	☐ Fibromyalgia
☐ Diabetes	☐ Stroke
☐ Joint Replacement (s)	☐ Blood Clots
☐ High/Low Blood Pressure	☐ Numbness
☐ Neuropathy	☐ Loss of Mobility
☐ Osteoporosis	☐ Sprains or Strains
☐ Headaches/Migraines	☐ Dislocation/Fractures

Explain any conditions you have marked above:

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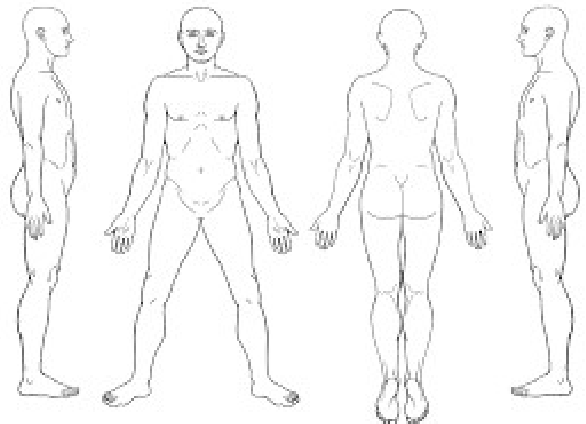
Stretch Information

Have you had a professional stretch before? ☐ yes ☐ no

Please circle any areas of discomfort



I understand that stretch therapy 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. ☐ yes

If I experience pain/discomfort during the session, I will immediately inform my therapist so that pressure can be adjusted to my level of comfort. I will not hold my therapist liable should I choose to not say anything if I have pain/discomfort. ☐ yes

I understand assisted stretching involves close physical contact between client and stretch coach. If at any time I am feeling uncomfortable, I will make the coach aware. _yes

The unexpected happens so if I am unable to keep my appointment, I will cancel ASAP. Late shows, if time allows will be honored depending on the schedule of the day. _ yes

Client Signature ________________________ *Date* ____________

Therapist Signature ______________________ *Date* ____________