STRETCH NV

Date _____

Stretch Tech _____

PERSONAL INFORMATION

Name _____ Age _____

Email _____ Cell Phone _____

Emergency Contact _____ Emergency Phone _____

STRETCH ASSESSMENT QUESTIONNAIRE

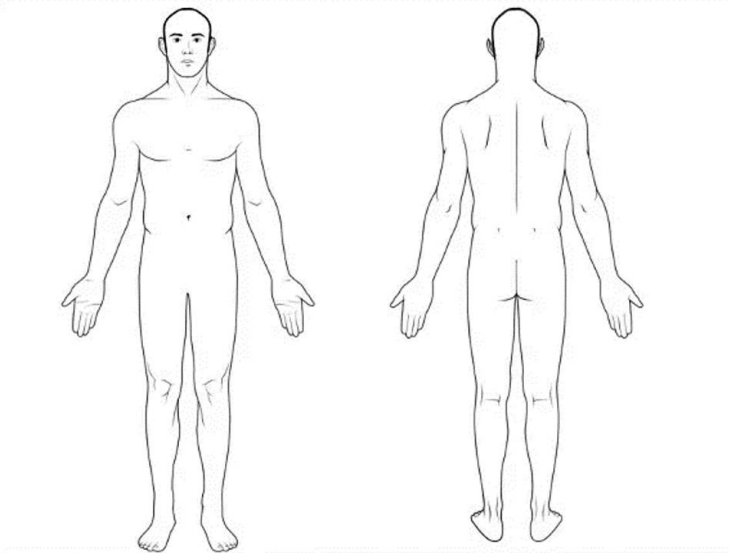
What is your specific goal regarding mobility? _____

List any previous injuries or surgeries we should be aware of_____

How many days a week are you physically active? _____

Is your occupation (Sedentary / Active) and do you primarily stand or sit most of the day? _____

What areas of your body do you feel are the tightest? Please circle all that apply:



Contraindications to Assisted Stretch (check all that apply)

- Limited movement at the joint due to the presence of a boney block
- Directly after fracture when it has not completely healed
- Acute inflammation or, infection
- Sharp pain during joint movement
- Hematoma or other soft tissue trauma
- Hypermobility
- Clearance from doctor to stretch post-Operation (within 3 months of surgery)

STRETCH NV

RELEASE OF LIABILITY

I, the undersigned, being aware of my own health and physical condition, and having knowledge that my participation in any exercise program may be injurious to my health, am voluntarily participating in physical activity with Stretch NV. Having such knowledge, I hereby release Stretch NV, their representatives, agents, and successors from liability for accidental injury or illness which I may incur as a result of participating in the said physical activity. I hereby assume all risks connected therewith and consent to participate in said program. I agree to disclose and physical limitation, disabilities, ailments, or impairments which may affect my ability to participate in said fitness program.

_____ _____

Client Signature Date

_____

Printed Name

_____ _____

Cosigner Signature (if applicable) Date

_____

Printed Name

_____ _____

Stretch Tech Signature Date

_____

Printed Name