CLIENT HISTORY and WAIVER

NAME:_____ DATE:_____

Mobile:_____ Email:_____

What brings you here for your visit?_____
_____
_____

Do you have: Pain _____ Numbness_____ Tingling_____ Aches_____

PAIN SCALE Between (1) LEAST and (10) MOST How would you rate your pain today?_____

Do you feel swelling_____, Cramping_____, stiffness_____, burning_____, Frozen_____?

Have you done anything for or gotten **any advice or treatment** for these issues? Yes _____ No_____
_____
_____

Is the condition **worse** during certain times of the day? When?_____

Are there any **other health concerns**? Past injuries? Past Accidents? Past surgeries?

_____
_____

How can you best **describe your birth**?
Hospital_____Home_____Cesarean_____Vacuum/Suction_____Forceps____ Induced_____

How is your **sleep** pattern? Hours per night? _____

LEG DIFFERENTIAL: LEFT LEG_____ RIGHT LEG_____

HEAD AND NECK RANGE OF MOTION:_____

****

REBALANCE TEST SECOND SESSION *DATE:*_____

LEGS: _____ *HEAD ROM:*_____

****

PRINT YOUR NAME:_____

SIGNATURE:_____

SIGNTURE OF PARENT OR GUARDIAN IS REQUIRED IF CHILD IS UNDER THE AGE OF 18 YEARS OLD:

_____

CERVICAL MUSCLE RELEASE

MASSAGE AND BODY WORK

WAIVER FORM

I hereby consent to and authorize the use and reproduction, in print or electronic format by Cervical Muscle Release / Valentia (Val) Kluge, of any and all photographs, video testimonials and written testimonials which have been taken for any advertising or marketing purpose, without compensation. All images—electronic, negatives and positives, together with the prints, are owned by Cervical Muscle Release / Valentia (Val) Kluge.

I hereby acknowledge that I am 18 years of age or older and have read and understood the terms of this release.

Name/Signature: _____

Date: _____

Signature of Parent/Guardian is required if child is under the age of 18.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____