



Name _____ Date: _____ Gender: _____ DOB: _____

Phone: _____ Email: _____

Emergency Contact: _____ Relation: _____ Phone: _____

What are your goals for Fascia Stretch Therapy?

- Reduce pain Improve performance Increase mobility Improve recovery Address instability
 Other: _____

SECTION 1: Pain & Movement

Where are you currently experiencing discomfort?

- Neck Shoulders Mid Back Low Back Hips Knees Ankles Other: _____

On a scale of 1–10, how would you rate your discomfort?

Is your pain: Constant Intermittent Activity-based Post-exercise Random

What movements feel most restricted?

Indicate where you have complaints, pain, or other symptoms.

When did your symptoms start?

How did your symptoms begin?

What describes the nature of your symptoms?

- Sharp Dull Ache Numb Shooting Burning Tingling

How are your symptoms changing?

- Getting Better Not Changing Getting Worse

What is the average intensity of your symptoms? (Circle One) 0 1 2 3 4 5 6 7 8 9 10

How much has pain interfered with your normal work (including academics, athletics, housework, and work outside the home)?

- Not at all A little bit Moderately Quite a bit Extremely

SECTION 2: Health History

Do you currently have any diagnosed conditions?

- Hypermobility Ehlers-Danlos Syndrome Autoimmune condition Chronic pain Disc injury
 Joint instability None Other: _____

Are you currently under the care of a physician, chiropractor, or physical therapist?

- Yes No If yes, please explain:

Have you had any surgeries or major injuries?

Are you currently pregnant?

- Yes No

SECTION 3: Hypermobility Screen

Have you ever been told you are hypermobile?

- Yes No Unsure

Do you frequently experience:

- Joint “slipping” or popping Feeling unstable in certain joints Chronic tightness despite stretching
 Frequent sprains None of the above

For Practitioner Use Only:

	LEFT	RIGHT
1. Passive dorsiflexion and hyperextension of the fifth MCP joint beyond 90°	1	1
2. Passive apposition of the thumb to the flexor aspect of the forearm	1	1
3. Passive hyperextension of the elbow beyond 10°	1	1
4. Passive hyperextension of the knee beyond 10°	1	1
5. Active forward flexion of the trunk with the knees fully extended so that the palms of the hands rest flat on the floor	1	1
TOTAL	/ 9	

SECTION 4: Activity & Goals

How would you describe your activity level?

- Sedentary
 Recreationally active
 Athlete
 Competitive athlete

What sports or training do you participate in?

SECTION 5: Nervous System Awareness

Have you received FST or other types of bodywork before?

How do you typically respond to bodywork?

- I relax easily I tense up I feel emotional I feel sore for days I'm unsure

Client Consent Form: Please read carefully and sign below. By signing this consent, I agree that I have stated all conditions that I am aware of and the information is true and accurate to the best of my knowledge. I will inform my health care provider, or practitioner if anything changes in my status. I understand that the bodywork I receive is for the purpose of increased flexibility, stress reduction, and relief from muscular tension, spasm or pain, and to increase circulation. If I experience any pain or discomfort, I will immediately inform my practitioner so that the intensity and/or methods can be adjusted to my comfort level. I understand that utilization of this type of modality can possibly increase soreness and/or pain if I do not communicate honestly and or follow proper precautions following the session. I understand that information exchanged during any session is educational in nature and is intended to help the client become more familiar and conscious of his or her own health status.



I understand that an FST Practitioner cannot diagnose illness, disease, or any physical or mental disorders. As such, the practitioner does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal or skeletal manipulations. It has been made very clear to me that this therapy is not a substitute for medical examinations and/or diagnosis, and I understand that it is my responsibility to consult a physician for any ailments I may have.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. I understand that I am choosing Fascia Stretch Therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid therapy I hereby hold harmless and release from any liability as well as any officers, directors, or employees of for any condition or result, known or unknown that may arise as a consequence of any treatment I receive. Sexual advances and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated, resulting in the immediate termination of the session and I will be liable for payment of the scheduled treatment. I agree to abide by a 24 hours cancellation notice for any scheduled appointment. I understand I may be liable for payment of the scheduled treatment. I understand I may be charged up to the full amount of the service for missed appointments or for any cancellations with less than a 24-hour notice. I understand that if I arrive late for an appointment, the session will end at the original scheduled time to prevent penalizing another client. However, if the practitioner is late, they will fulfill the scheduled appointment length or offer a reasonable compensation.

Hypermobility Disclaimer & Informed Consent: Some clients naturally have greater joint range of motion, commonly referred to as **hypermobility**. Hypermobility is not an injury or condition in itself; however, it may require a modified, stability-first approach to movement and fascial work.

By participating in sessions, you acknowledge that stretching, fascial techniques, and movement practices will be adapted to prioritize **mid-range control, nervous system regulation, and joint support** rather than end-range stretching. You understand that deeper or aggressive stretching is not always appropriate for hypermobile bodies and may be intentionally limited for your safety and long-term benefit.

You agree to communicate openly about sensations during and after sessions, including delayed discomfort, feelings of instability, or increased pain. You understand that temporary soreness or nervous system responses can occur as the body adapts to new input, and that these responses do not necessarily indicate injury.

By continuing with services, you consent to a **hypermobility-informed approach** that emphasizes stability, awareness, and gradual progression, and you acknowledge that it is your responsibility to follow post-session guidance and avoid additional stretching or activities that may compromise joint support during recovery periods.

Checkbox: I have read and agree.

Client Name: _____ Date: _____

Client Signature: _____ Parent's Signature: _____ (If under 18 years of age)