402 Park Road, West Hartford, CT 06119 / info@shadowandtrees.com / (860) 841-7485
Matt DeMichele, Licensed Massage Therapist
CT License #: 005135

==========**ACTIVE ISOLATED STRETCHING INTAKE FORM** ==========

_____ _____
Name Birth Date

_____
Address (Number, Street Name, Apt. #, Town/City, State, Zip Code)

_____ _____ _____
Home Phone Number Work Phone Number Cell Phone Number

How did you hear about us?_____ E-mail Address_____

What physical activities or sports do you participate in?
_____
_____

Have you ever done Active Isolated Stretching before? ☐ Yes ☐ No

Do you incorporate stretching into your exercise and/or daily regimen? ☐ Yes ☐ No If yes, please elaborate below.
_____
_____
_____

What medications do you take?
_____

Please describe any medical conditions and/or injuries, movement limitations, muscle tightness, chronic issues/weaknesses or imbalances (previous or current) that affect you: Any surgeries within the past 5 years and/or any acute injury or trauma? (Please list dates if known)
_____
_____
_____
_____

Do you have any specific movement and/or fitness goals that you're looking to accomplish specifically with Active Isolated Stretching? ☐ Yes ☐ No If yes, please describe them below.
_____
_____

List any doctors you see along with their phone number(s). May we contact them? ☐ Yes ☐ No
_____

Are you currently or are you trying to become pregnant? ☐ Yes ☐ No

Please list any surgeries, injuries, and any movements you have been informed by your doctor not to perform. Explain limitations you experience in detail.

_____
_____
_____
_____
_____
_____

INFORMED CONSENT

By signing this document, I acknowledge that I am voluntarily engaging in Active Isolated Stretching (AIS) at Shadow & Trees Massage Therapy. I understand the risks involved with participating in AIS. In the event that a medical clearance must be obtained prior to my participation in AIS, I agree to consult with my physician and obtain written permission from him/her prior to the commencement of any service received at Shadow & Trees Massage Therapy. I also acknowledge that I have the right to cease activity at any point during the AIS session in the event of pain/significant discomfort. In signing this consent form, I affirm that I have read this form in its entirety and that I have appropriately disclosed all relevant and pertinent health history information to the practitioner.

I AFFIRM THAT I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE STATEMENTS.

Signature _____ Date _____

CANCELLATION POLICY

Shadow & Trees Massage Therapy has a 24-hour cancellation policy for all sessions. Late cancellation for sessions (either Active Isolated Stretching, Massage Therapy, and/or Energy Work) may be charged $40, and no shows will be charged the full value of the session missed.

I AFFIRM THAT I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE STATEMENTS.

Signature _____ Date _____