Sydney Stretch Therapy
Suite 13, Level 3, 88 Pitt Street
Sydney NSW 2000
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Welcome To Sydney Stretch Therapy Course or Classes

Date: _____ Referred by: _____

Name: _____

Occupation: _____

Address: _____

_____

Email:_____

Mobile: _____Work: _____Home: _____

Birthday: _____

Medical or Physical History I need to know about before starting:

What are your expectations for this course? _____
_____
_____

Weekly exercise type and duration: _____
_____
_____

Other stress reduction or leisure activities: _____
_____

Are you pregnant? _____ How many weeks? _____

List any injuries, illnesses or surgeries? _____
_____
_____

Do you have frequent or chronic pain? _____
When did this start & how? _____
Where? _____ Worse when…_____
Are you still under a physicians care? _____
List all current medications, painkillers and supplements: _____
_____

I the undersigned agree the above information is accurate and true to the best of my knowledge and that I do not have any injuries or physical ailments, which would prevent me from undertaking a Stretch Therapy course at my own risk.
I further agree that if I do have any chronic problems, that I have sought qualified professional advice, and that I am able to attend at any level, without risk to myself. I agree not to hold the Stretch Therapy Instructor, or their agent for any injuries that may arise from attending a Stretch Therapy course.
I understand that a refund is not available once the course has commenced.

Signature_____Date_____